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

BENEFIT INFORMATION

-for-

MANAGEMENT CAFETERIA PLAN

Including

Comparisons of Health and Dental Plans and Information on all Voluntary Benefits

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PLAN YEAR
OCTOBER 1, 2000 – SEPTEMBER 30, 2001

OPEN ENROLLMENT PERIOD
AUGUST 7, 2000 – AUGUST 25, 2000

OPEN ENROLLMENT INFORMATION SITES

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

DATE/TIME	LOCATION	ADDRESS
Monday, August 21 Tuesday, August 22 Friday, August 25 8:00 a.m. – 4:45 p.m.	HSS Office	1145 Market, 2nd fl., SF
Thursday, August 17 10:30 a.m. – 2:00 p.m.	SF General Hospital	Main Hospital Bldg., 2nd Fl. 1001 Potrero Ave., SF
Thursday, August 24 9:00 a.m. – 4:30 p.m.	Laguna Honda Hospitai	B102 Conference Room 375 Laguna Honda Blvd., SF
TO BE DETERMINED	Hetch Hetchy	Junction 120 & 49, Moccasin
Friday, August 18 9:00 a.m. – 4:30 p.m.	Hall of Justice	850 Bryant Street, SF Room 505
Monday, August 7 thru Friday, August 11 9:00 a.m. – 4:30 p.m.	War Memorial	401 Van Ness Avenue Rooms 212 & 213
Monday, August 14 9:00 – 4:30 p.m.	Ferry Building	Room 3100
Tuesday, August 15, Wednesday, August 16 9:00 a.m. – 4:30 p.m.	Airport – DHR	(Tues) – Int'l Terminal – VIP Rm. (Wed) – Int'l Terminal – Rm. 590B
Wednesday, August 23 9:00 a.m. – 4:30 p.m.		875 Stevenson, SF 5th Floor Resource Room

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)
Website: www.ci.sf.ca.us/dhr

HEALTH PLANS	DENTAL PLANS
Kaiser Foundation Health Plan, Inc. 2425 Geary Boulevard San Francisco, CA 94115 (800) 464-4000 Group No. 888 **Website: www.ca.kaiserpermanente.org** **Member website: www.kponline.org**	**Delta Dental** P.O. Box 7736 San Francisco, CA 94120 (888) 335-8227 (888) 4-AREA-DR (referrals to Delta dentists) Group No. 9502-0003 City Employees **Website:** www.deltadentalca.org
HealthNet 155 Grand Avenue Oakland, CA 94612 (800) 522-0088 Group No. 61515 **Website: www.healthnet.com**	**PMI Dental Health Plan** 12898 Towne Center Drive Cerritos, CA 90703 (800) 422-4234 Group No. 3461 **Website:** www.deltadentalca.org
PacifiCare 2300 Clayton Road Suite 1000 Concord, CA 94520 (800) 624-8822 Group No. 403214 **Website: www.pacificare.com**	**Pacific Union Dental** 1390 Willow Pass Road, Ste. 800 Concord, CA 94520 (800) 999-3367 (925) 363-6000 Group No. 94227
City Health Plan 1145 Market Street, Suite 200 San Francisco, CA 94103 (415) 554-1725 (800) 795-2351 outside 415 Area Code	
CHEMICAL DEPENDENCY TREATMENT	**DEPENDENT CARE & MEDICAL REIMBURSEMENT ACCOUNTS**
United Behavioral Health P.O. Box 23250 Oakland, CA 94623-0250 (800) 888-2998 **Website: www.ubnet.com**	**Employee Benefit Specialists, Inc.** **P.O. Box 11657** **Pleasanton, CA 94588** **(800) 229-7683** www.ebsbenefits.com
VISION CARE PLAN	**ALL OTHER VOLUNTARY BENEFITS**
Vision Service Plan P.O. Box 254500 Sacramento, CA 95865-4500 (800) 877-7195 **Website: www.vsp.com**	**Employee Benefit Specialists, Inc.** **P.O. Box 11657** **Pleasanton, CA 94588** **(800) 229-7683** **www.ebsbenefits.com**

SAN FRANCISCO HEALTH SERVICE SYSTEM

A DIVISION OF THE DEPARTMENT OF HUMAN RESOURCES
1145 Market Street, 2nd Floor
San Francisco, CA 94103

August 2000

Dear Participant (or Prospective Participant) in the Management Cafeteria Plan:

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

Many people do not realize that the Health Service System actually maintains two different flexible benefit plans: this one for municipal executives and managers and a second one for other members of the Health Service System. This plan has a plan year that commences on October 1 and ends on September 30, while the other plan has a plan year that corresponds to the City's fiscal year (July 1-June 30). This plan has a broad range of different benefits and operates on a classic fixed-contribution cafeteria plan model, while the other is limited in its scope of benefits and relies on assorted funding mechanisms. This plan currently uses EBS as its third-party administrator, while the other plan currently uses Fringe Benefits Management Company.

Therefore, in order to keep the plans clear and distinct in everyone's (including our) minds, we're now referring to this plan as "the Management Cafeteria Plan." While the name has changed, the structure of the plan has not.

Finally, we welcome your feedback throughout the year on the quality of service you receive from EBS and the Health Service System. Please tell us about what you like and don't like so that we can continue making progress toward our customer service goals.

Very truly yours,

HEALTH SERVICE BOARD

Scott Heldfond, President
Claire Zvanski, Vice President
James Deignan
Jean Fraser
Harry Paretchan
Melissa Welch, MD
Leland Yee, Member, Board of Supervisors

DEPARTMENT OF HUMAN RESOURCES

Andrea Gourdine, Director
Bart Duncan, Acting Deputy Director, HSS

EMPLOYEE BENEFIT SPECIALISTS, INC.

Joan Rhodes, President

Table of Contents

CONTACT INFORMATION ____ 1

Management Cafeteria Plan Letter ____ 2

Important Information -- Read This First! ____ 5

How Open Enrollment Works ____ 7

Changes You May Make During Open Enrollment ____ 7

No Changes Allowed After Open Enrollment Closes On August 25 ____ 7

Management Cafeteria Plan for Each Benefit ____ 8

Benefit Plans Offered By HSS ____ 9

Benefit Plans Through Management Cafeteria Plan ____ 10

Health Club and Fitness Program Reimbursement ____ 11

Executive and Personal Coaching ____ 11

State Disability Insurance Premium Reimbursement ____ 11

Prior Service Buy Back ____ 11

Tuition Reimbursement ____ 11

San Francisco Cultural and Entertainment Event Reimbursement ____ 12

Long-Term Care Insurance or Reimbursement Account ____ 12

PERS ____ 12

John Hancock ____ 12

Universal Life Insurance ____ 12

Veterinary Pet Insurance ____ 13

Auto Insurance ____ 13

Voluntary AD&D ____ 13

Cancer Intensive Care Insurance ____ 13

Heart and Stroke Insurance ____ 13

Short-Term Disability ____ 13

Accident Insurance ____ 14

Group Term Life Insurance ____ 14

Long-Term Disability ____ 14

Commuter Check ____ 15

IMPORTANT INFORMATION -- READ THIS FIRST!

This Booklet Provides Only An Overview -- Consult The Individual Plan Booklets and Materials Details.

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

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

The Management Cafeteria Plan is available to all employees represented by the Municipal Executives Association, elected officials and some other unrepresented managers. **For the 2000-2001 Plan year, you will receive a City contribution of $121.96 bi-weekly to spend on benefits.**

You Need To Submit Social Security Numbers For Your Enrolled Dependents Even If You Make No Other Changes.

HSS now 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, use the separate form provided in this package** to submit your dependents' social security numbers.

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 may be required. If you have enrolled dependents who are not eligible, you must repay all expenses paid for them, and you may face additional penalties.

Enroll New Dependents Within 30 Days.

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

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

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

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

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

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

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

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

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

If you are not using your entire flex credit contributions toward the Health Plan of your choice, you must allocate you flex credits in $25 increments for health benefits.

How Open Enrollment Works

Changes You May Make During Open Enrollment

During the Open Enrollment period (August 7 – August 25) 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.
- Enroll or re-enroll in the Flexible Spending Accounts (Health Care and Dependent Day Care). **You must re-enroll in the Flexible Spending Accounts each year.**
- Enroll in, modify or cancel any of the voluntary benefits offered under the Management Cafeteria Plan.

Your new coverage begins October 1, 2000 and continues through September 30, 2001, provided you and your dependents remain eligible. The Health and Dental benefit plans you select (except Delta Dental) will send you and your dependents membership/identification cards directly to your home. Until you receive those cards, you should use the group identification numbers listed in the contact information on the first page of this booklet.

Submit Social Security Numbers For All Your Dependents To Maintain Your Current Benefits.

In previous years, you didn't need to do anything if you didn't want to change your benefits. **This year, you must give HSS the social security numbers of all of your dependents. You can obtain a form from an enrollment counselor or from HSS, or may use your enrollment application.**

No Changes Allowed After Open Enrollment Closes On August 25

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

EBS enrollment counselors have to submit all signed forms to HSS by August 31

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

You cannot make any changes to your benefits after August 25 unless the change is on account of and consistent with a qualifying change in family status (marriage, divorce, birth or death of a dependent, etc.).

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

Benefit Section 125 Plan	**Tax Status**	**Flexible Credit**	**Payroll Deduction**
Medical Insurance	**Pre-Tax**	**Yes**	**Yes**
Medical Reimbursement Account	**Pre-Tax**	**Yes**	**Yes**
Adoption Assistance Reimbursement Account	**Pre-Tax**	**Yes**	**Yes**
Dependent Care Account	**Pre-Tax**	**Yes**	**Yes**
Long Term Disability	**Pre-Tax**	**Yes**	**No**
Short Term Disability	**Pre-Tax**	**Yes**	**Yes**
Cancer Insurance	**Pre-Tax**	**Yes**	**Yes**
Accident Insurance	**Pre-Tax**	**Yes**	**Yes**
Heart and Stroke Insurance	**Pre-Tax**	**Yes**	**Yes**

$50,000 Term Life Insurance provided at no cost to all employees eligible for the Management Cafeteria Plan

Benefit Non-Section 125 Plan Benefit Options	**Tax Status**	**Flexible Credit**	**Payroll Deduction**
Universal Life Insurance	**Post-Tax**	**Yes**	**Yes**
Supplemental Term Life Insurance	**Post-Tax**	**Yes**	**No**
Dues Reimbursement	**Post-Tax**	**Yes**	**No**
Commuter Check	**Both***	**Yes**	**Yes**
Health Club and Fitness Reimbursement Account	**Post-Tax**	**Yes**	**No**
Veterinary Pet Insurance	**Post-Tax**	**Yes**	**Yes**
Long Term Care	**Post-Tax**	**Yes**	**Yes**
Auto and Homeowners Insurance	**Post-Tax**	**Yes**	**Yes**
Accidental Death and Dismemberment Insurance	**Post-Tax**	**Yes**	**Yes**
Cultural, Arts and Entertainment Reimbursement	**Post-Tax**	**Yes**	**No**
California State Disability Premium Reimbursement	**Post-Tax**	**Yes**	**No**
Professional Coaching	**Post-Tax**	**Yes**	**No**
Excess Tuition Cost Reimbursement	**Post-Tax**	**Yes**	**No**
Prior Service Buy Back Reimbursement	**Post-Tax**	**Yes**	**No**
Group Legal Plan	**Post-Tax**	**Yes**	**Yes**

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

Benefit Plans Offered By HSS

Health Plans. The following health plans are available:

- Kaiser[1]
- HealthNet[1]
- PacifiCare[1]
- City Health Plan

Dental Plans. The following dental plans are available:

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

Chemical Dependency Benefit. A chemical dependency (alcohol, drugs, etc.) rehabilitation benefit is provided automatically to all employees and eligible dependents. Kaiser members receive this benefit through Kaiser and should contact Kaiser if they need assistance. Members of other health plans receive this benefit through United Behavioral Health, whose contact information is listed on the first page of this booklet.

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

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

Benefit Plans Offered Through the Management Cafeteria Plan

Adoption Assistance Account
This program provides an exclusion from an employee's gross income on a pre-tax basis for amounts paid or expenses incurred by an employee for qualified adoption expenses in connection with the adoption of an eligible child by an employee if such amounts are furnished pursuant to an adoption assistance. **See Adoption Assistance Account,** page 32 for details.

Medical Reimbursement Account
Employees can set aside employer and employee dollars on a pre-tax basis to fund this account up to $5,000 per plan year. **See Health Care Flexible Spending Account**, page 28 for details.

Dependent Care Account
Employees can set aside employer and employee dollars on a pre-tax basis to fund this account up to $5,000 per plan year. **See Dependent Day Care Flexible Spending Account**, page 30 for details.

MEA Dues Reimbursement: This post-tax reimbursement program can be used to reimburse your MEA dues. MEA members sign up for a payroll deduction to pay their Association dues, then elect to have those dues reimbursed to them with after-tax employer dollars once a month. EBS receives a payroll deduction report from PPSD to verify the deductions taken for the period, so no claim forms are required for MEA dues reimbursement.

Other Dues Reimbursement: The dues reimbursement account has been expanded this year to include other professional dues and auto club dues. This is a post-tax reimbursement account. Ask your enroller if your professional association dues qualify. The dues reimbursement program also includes Auto Club Dues for the plan year beginning October 2000. For all dues other than MEA dues a claim form is required in order to be reimbursed.

Health Club and Fitness Program Reimbursement
Members can allocate employer dollars on an after tax basis to the account. Participants are reimbursed once a month 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). Reimbursements can be via check or direct deposit. Employees send in claims for their expenses and are reimbursed on a monthly schedule. This is a post-tax reimbursement account.

Executive and Personal Coaching
Through the Management Cafeteria Plan you can use employer dollars on a post-tax basis for professional and personal coaching with Audree Halasz of Axis Coaching (415) 863 7331. For more information please check out **www.axiscoaching.com**. Audree works with clients on leadership, professional and personal issues creating a partnership to help you achieve more of what you want in life. Champion athletes use coaches to make their game legendary. Audrey's coaching gives that same exceptional one-on-one support and motivation for your personal and professional life. Please be sure to contact Audree before your enrollment to design your coaching program. Everybody is different and coaching helps you focus on your goals in life.

State Disability Insurance Premium Reimbursement
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 for some or all of that cost. You must have a payroll deduction for this benefit in order to be reimbursed. You do not have to send in claims for this benefit. Reimbursements will be sent once a month by check or you can sign up for direct deposit. Reimbursements are post-tax for this benefit.

Prior Service Buy Back
If you are having a San Francisco retirement service withholding from your paycheck to purchase "prior service" you may choose to be reimbursed from the flex plan. You must have a payroll deduction to be reimbursed. The reimbursement program is for payments made from October 2000 forward, there are no retroactive reimbursements for payments made prior to the beginning of the new plan year. Funds received under this benefit are taxable.

Tuition Reimbursement
If you are participating in any training program and you have exceeded your $500 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 $500 for classes that qualify. This plan is being offered on a post-tax basis.

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 SF Zoo, Academy of Science, Opera, Asian Art Museum, deYoung Art Museum, SF Symphony, the SF Ballet etc. will qualify for reimbursement. You can be reimbursed for membership, season or individual tickets, or other contributions. You will need to submit claims with receipts attached to be reimbursed for these expenses. This is a post-tax reimbursement account.

Long-Term Care Insurance or Reimbursement Account

(a) **PERS** – There are two ways to purchase long-term care through the Management Cafeteria Plan. If you are purchasing long-term care through PERS you may be reimbursed on a post-tax basis for some or all of that premium cost. PERS holds enrollment for the Long-Term Care in the spring of each year. Employees must enroll through PERS directly for this benefit. Any employee who has signed up for the PERS long-term care program can set aside some employer dollars on an post-tax basis to reimburse themselves for some or all of the cost of this program. The participants in this benefit must send in claims to EBS' office to show that they are incurring costs for this program. EBS will mail reimbursement checks or direct deposit the funds as requested.

(b) **John Hancock** – You can purchase coverage through John Hancock The premiums will be paid directly to the carrier for this plan. The enrollment counselors can assist you in deciding which plan works best for you. The plan is flexible and allows you to cover yourself, your spouse, your parents, grandparents, and in-laws.

Universal Life Insurance
This plan is designed to provide permanent insurance protection coupled with cash accumulation. Members can purchase this life insurance protection in amounts from $5,000 to $500,000 for non-smokers and ($250,000 for smokers), subject to current underwriting guidelines of the insurance carrier. The cash accumulation feature of the policy will earn current market interest on a tax-deferred basis, with a minimum of 4.5% interest compounded annually. In addition the plan allows employees to cover their spouse and dependents, whether they cover themselves or not. One of the main benefits of this type of insurance is that employees own the policy and can continue the coverage even if they leave CCSF. Many employees keep this coverage into retirement. The majority of employees today have term insurance provided by their employer (Management Cafeteria Plan members have such insurance in the amount of $50,000) which ceases when they terminate. Term insurance premiums increase as the participant ages, so at retirement term costs can be significant, making this benefit valuable for many employees who need life insurance past their working years. Coverage can be purchased for spouses, domestic partners and children. This is a post-tax benefit.

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

Auto Insurance
Auto insurance offers participants the convenience of payroll deduction or the use of flex credit to pay their auto insurance bills, and monthly billing can ease the financial burden that semi-annual or annual billing causes for many households. Also, being part of a group can create savings to some drivers with less than perfect driving records. The plan is being offered through Liberty Mutual. This is a post-tax benefit.

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

Cancer Intensive Care Insurance
This plan is designed to assist insureds with the out-of-pocket costs associated with cancer treatment. While, medical plans may cover most of the actual medical costs of cancer treatment, there are usually other costs incurred that are not reimbursed, such as the cost of being out of work, hiring in-house assistance for house cleaning and/or childcare etc. The intensive care portion of this plan is an optional rider to pay daily benefits while the insured is in intensive care for any reason not just for cancer treatment. Employees can use pre-tax employer or employee dollars to fund the purchase of this benefit.

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

Short-Term Disability
Participants can elect to have flex dollars or payroll deductions to pay for the Reliastar or Colonial short-term disability policies on a pre-tax basis. You may elect coverage under either carrier based on your needs. The short-term disability policy is designed as an income replacement policy in the event that an insured is disabled due to an injury or sickness. The plans have various elimination and benefit periods to choose from. The elimination period

is the amount of time that the insured has to be out of work due to a disability before the policy begins paying. The longer the elimination period the lower the cost. The benefit period is the amount of time that the insured will be paid benefits. There is a benefit period as short as three months available, to coordinate with the long term disability policy.

Accident Insurance

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

Group Term Life Insurance

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

Long-Term Disability

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

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

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

Wells Fargo Benefit
If you are an active MEA member you are eligible for a program through Wells Fargo offering reduced mortgage costs, free checking, low interest credit cards and other benefits. There is no cost to 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.

475 members $13,585/mo

$\bar{X}$ = $28.60/mo

HEALTH PLANS

An Overview Of The Different Types Of Health Plans

Health Maintenance Organizations - Kaiser, HealthNet, PacifiCare.

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, HealthNet and PacifiCare.

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

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

To participate in an HMO you <u>must</u> 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.

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

The percentage of the cost of medical services that the City Health Plan will pay depends on two things -- whether you use a preferred provider, and where you live. A preferred provider is a medical provider who agrees to provide health care services to City Health Plan members at a discounted rate. The City Health Plan will pay a higher percentage of the cost of your care if you use a preferred provider. In addition, you usually do not need to file a claim form if you use a preferred provider. However, you still need to pay the deductible, and you still must pay a portion of the cost of services.

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 proportion of your medical costs than if you lived in one of the nine Bay Area counties, but lower than if you used a preferred provider. The nine Bay Area preferred providers counties are: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, Solano, Sonoma, and Tuolumne.

Changes To The Health Plans Since Last Year

For your convenience, we have asked the health plans to identify for you the major changes in their plans since last year. **You should always consult the benefit plan booklets available from each of the health plans for details as to their actual benefits.**

AB88: Mental Health Parity Act

In compliance with the AB88 Mental Health Parity Act of 1999, the following changes are incorporated into all the health plans.

Members will receive benefit coverage for the diagnosis and medically necessary treatment of serious emotional disturbances (SED) of a child and severe mental illnesses (SMI), including:

- Schizophrenia
- Schizoaffective Disorder
- Bipolar Disorder
- Major Depressive Disorder
- Panic Disorder
- Obsessive-compulsive Disorder
- Pervasive Developmental Disorder and Autism
- Anorexia
- Bulimia Nervosa

Changes To Kaiser

- Drug Benefits ($5 copay) changed from 30 day supply to 100 day supply
- Allergy Shot copay changed from $3.00 to $5.00
- Emergency room copay changes from $5.00 to $35.00
- Chiropractic benefit $10.00 copay, 30 visits per year
- Urgent care facilities provide additional weekend and evening hours (see the guide book to Kaiser Permanente Services for specific facilities or go to their website for information)

- Members only website: www.kponline.org which is an interactive website with the health information , advice nurses, appointment scheduling
- General Internet access: www.ca.kaiserpermanente.org
- Health advice nurses available 7 days a week, 24 hours a day
- Health phone - Free Recorded Health Messages 24 hours a day
- Extensive Health Education classes and information
- K-Plus for fitness – financial discount at participating health clubs (Information Line 800 234-6985)
- Healthwise Handbook – Self care guide provided free of charge to all members

Changes To HealthNet

HeatlthNet will offer the following new programs:

- Mills Peninsula Medical Group and Hospital are now available: 102 Primary Care Physicians, 257 specialists.
- Emergency room copay changed from $25.00 to $35.00
- Chiropractic benefit $10.00 copay, 30 visits per year
- Healthline 24-hours, 7 days a week nurse assistance
- Well Rewards, discounts on supplements, exercise equipment, acupuncture, massage therapy, gym membership, etc.
- Member appeals process: automatic third-party review
- $5.00 visit to outpatient Mental Health. Unlimited visits
- Internet access: www.healthnet.com

Changes To PacifiCare

PacifiCare offers the following new programs:

- Chiropractic benefit $10.00 copay, 30 visits per year
- Internet access: www.pacificare.com
- Mills Peninsula Medical Group is now available
- Health improvement programs, stop smoking, etc.
- Quality index available on medical groups.

Changes To The City Plan

City Health Plan offers the following new programs:

- Mills Peninsula Medical Group and Hospital are now available
- Lifetime maximum benefit increased from $1 million to $2 million
- Limit occupational and physical therapy visits to 60 visits combined per benefit year
- Change out-of-pocket limits to $3,750 in-network and out-of-area, $7,500 out-of-network (all of these limits include the deductible), family limits 3 times the above.
- Cover non-emergency treatment during travel outside the U.S., subject to the same standards as would be used if the treatment were provided within the U.S.
- Change the out-of-network deductible from $500 to $250.

SECTION VII
COMPARISONS OF BENEFITS FOR ACTIVE EMPLOYEES
HEALTH PLANS FOR ACTIVE EMPLOYEES

CITY HEALTH PLAN			
A member can choose to use either the Standard Plan or the Preferred Provider Program each time medical care is needed. It is important to know that continued participation of any one doctor, hospital or other provider cannot be guaranteed under the Preferred Provider Plan.			
	Reimbursement to Member residing In The Preferred Provider Area Using Non Preferred Provider	**Reimbursement to Members Residing Outside Of The Preferred Provider Area Using Non Preferred Provider**	**Preferred Provider Program**
Annual Medical Deductible	Same as Preferred Provider.	Same as Preferred Provider.	Employee only: $250 Employee + 1: $500 Employee + 2 or more: $750
Hospital: Inpatient Outpatient	50% after annual deductible. 50% after annual deductible.	80% after annual deductible. 80% after annual deductible.	85% after annual deductible. 85% after annual deductible.
Hospital Emergency Room	50% after annual deductible.	80% after annual deductible.	85% after annual deductible.
Physician Care Office/Home/ Hospital Visits Allergy Testing/ Treatment Immunization/ Inoculation Gynecological Exam Well Baby Care	 50% after annual deductible. 50% after annual deductible. 50% after annual deductible. 50% after annual deductible. 50% after annual deductible.	 80% after annual deductible. 80% after annual deductible. 80% after annual deductible 80% after annual deductible. 80% after annual deductible.	 85% after annual deductible. 85% after annual deductible. 85% after annual deductible. 85% after annual deductible. 85% after annual deductible.
Surgical	50% after annual deductible.	80% after annual deductible.	85% after annual deductible. Prior authorization may be required.
Outpatient Diagnostic X-ray and Laboratory	50% after annual deductible.	80% after annual deductible.	85% after annual deductible.
Routine Physical	Not covered	80% after annual deductible.	85% after annual deductible.
Maternity	50% Newborn must be enrolled with HSS within 30 days of birth.	80%. Newborn must be enrolled with HSS within 30 days of birth.	85%. Newborn must be enrolled with HSS within 30 days of birth.
Mental Health Care	Inpatient: 50% to max of 20 hospital days per year after annual deductible. Inpatient Physician: 50% to max of 25 visit after annual deductible. Outpatient: 50% to max of 25 visit per year after annual deductible	Inpatient: 80% to max of 20 hospital days per year after annual deductible. Inpatient Physician: 80% to max of 25 visit after annual deductible. Outpatient: 80% to max of 25 visit per year after annual deductible	Inpatient: 85% to max of 20 hospital days per year after annual deductible. Inpatient Physician: 85% to max of 25 visit after annual deductible. Outpatient: 85% to max of 25 visit per year after annual deductible
Prescription Drugs	Same as preferred provider	Same as preferred provider	**30** Day Supply. **$18**-Brand drug - **$9**-generic after annual Prescription Deductible of $50 per person. **Mail** Order **$36/$18** Copay Per **90**-Day Supply after Annual Prescription Deductible
Physical / Occupational Therapy combined	50% to max 60 visits after annual deductible.	80% to max 60 visit s after annual deductible.	85% to max 60 visit s after annual deductible.
Chiropractic Care	50% after annual deductible. $1,000 per benefit year.	Same as Standard Plan.	Same as Standard Plan.
Acupuncture Care	50% after annual deductible. $1,000 per benefit year.	Same as Standard Plan.	Same as Standard Plan.
Extended Care/ Skilled Nursing Facility	50% after annual deductible up to 120 days. Custodial care not covered.	80% after annual deductible up to 120 days. Custodial care not covered.	85% after annual deductible up to 120 days. Custodial care not covered.
Hospice	50% to max $10,000 Prior authorization required.	80% to max $10,000 Prior authorization required.	85% to max $10,000. Prior authorization required.
Alcohol and Drug Abuse Treatment	In hospital: 50% after annual deductible. Detox only and limited to medically certified days per admission. Rehab treatment programs covered.	80% after annual deductible. Detox only and limited to medically certified days per admission. Rehab treatment programs covered.	In hospital: 85% after annual deductible. Detox only and limited to medically certified days per admission. Rehab treatment programs covered.
Durable Medical Equipment	50% after annual deductible. Prior authorization required.	80% after annual deductible. Prior authorization required.	85% after annual deductible. Prior authorization required.
Vision Care	Same as Preferred Provider.	Same as Preferred Provider.	Exam, lenses and frames furnished every 24 months. $10 copay for exam; $25 copay for lenses and frames if provided by VSP provider.

THIS IS A SUMMARY OF BENEFITS ONLY
NOT A CONTRACT

	KAISER PERMANENTE	HEALTH NET	PACIFICARE
Provider of Service	Services are provided at Kaiser Permanente medical facilities only. You must live in the service area.	You must live in the service area. Check the zip codes.	You must live in the service area. Check the zip codes.
Annual Medical Deductible	None	None	None
Hospital: Inpatient Outpatient	 No charge. $5 per visit	 No charge No charge	 no charge no charge
Hospital Emergency Room	$35 co-pay, waived if hospitalized. $5/visit at Urgent Care Center	$35 copay, waived if hospitalized. $15 copayment at an Urgent Care Center.	$35 copay, waived if hospitalized.
Physician Care Office/Home/ Hospital Visits Allergy Testing/ Treatment Immunization/ Inoculation Gynecological Exam Well Baby Care	 5$5/No charge $5 visit No charge $5 visit $5 visit	 $5$5/No charge $5 visit/$5 injection No charge $5 visit $5 visit	 $5$5/No charge $5 copay $5 copay $5 copay $5 copay
Surgical	In hospital: no charge. Doctor's office: $5 visit.	In hospital: no charge. Doctor's office: $5 visit.	In hospital or doctor's office: No charge
Outpatient Diagnostic X-ray and Laboratory	No charge.	No charge.	No charge
Routine Physical	$5 visit	$5 through age 17 $25 Adults	$5 copay
Maternity	Hospital: no charge. Doctor's Office: $5 per visit. **Newborn must be added within 30 days of birth.**	Hospital and physician: no charge. **Newborn must be added within 30 days of birth.**	Hospital and physician: No charge **Newborn must be added within 30 days of birth.**
Mental Health Care	Inpatient: no charge to max of 45 days a year. Outpatient: $5 per visit	Inpatient: no charge for 30 days max a year. Outpatient: $5 per visit – unlimited visits	Inpatient: No charges for unlimited days Outpatient: Unlimited visits covered with $5 copay.
Prescription Drugs	$5 copay per 100 day supply, generic drug or prescribed medically necessary brand name drug, according to health plan formulary. Mail order available for refills.	$5 copay per 34 day supply. $15 copay for non-formulary medications. 90 days supply available through mail order program.	$5 copay per 30 day supply.
Physical Therapy	$5/visit up to 60 day period per condition or as authorized by plan physician.	$5/visit up to 60 day period.	$5/visit.
Chiropractic Care	$10 copay, 30 visit per year	$10 copay, 30 visit per year	$10 copay, 30 visit per year
Acupuncture Care	Not covered unless authorized	Not covered	Not covered
Extended Care/ Skilled Nursing Facility	No charge up to 100 days per benefit period.	No charge to a max of 60 days per year.	No charge to a max of 100 calendar days following a new qualifying condition.
Hospice	Covered when selected as an alternative to traditional service and authorized by plan physician.	Covered in full.	No charge up to maximum of 180 days lifetime maximum.
Alcohol and Drug Abuse Treatment	Inpatient: No charge for short term detoxification. Outpatient: $5 individual, $2 group. No charge to max of 30 days of residential treatment.	In patient: No charge for short term detoxification. Outpatient: Rehabilitation treatment programs covered.	Inpatient: no charge short term detoxification. Rehabilitation treatment programs covered. $25,000 annual maximum; $35,000 lifetime maximum.
Durable Medical Equipment	No charge when prescribed by plan physician and in accordance with Health Plan DME formulary guidelines.	No charge when medically necessary and authorized.	No charge
Vision Care	Exam, lenses and frames furnished every 24 months @ $5/exam, no charges for lenses, and $80 frame allowance. Contact allowance $124	$5 copay for exam referred by primary care physician. Lenses and frames provided by VSP	$5 copay exam if referred by PCP. VSP for eyeglass benefit

Service Areas By Health Plan.

✱ VERIFY YOUR ZIP CODE W/ PLAN

County	City Health Plan	Kaiser	HealthNet	PacifiCare
Alameda	■	■	■	■
Alpine	■			
Amador	■	■ some zip codes ✱	■	■
Butte	■		■	■
Calaveras	■			
Colusa	■		■	
Contra Costa	■	■	■	■
Del Norte	■			
El Dorado	■	■ some zip codes ✱	■	■
Fresno	■	■ some zip codes ✱	■	■
Glenn	■		■	■
Humboldt	■		■	■
Imperial	■	■ some zip codes ✱	■	■
Inyo	■			
Kern	■	■ 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	■		■	■
Orange	■	■	■	■
Placer	■	■ some zip codes ✱	■	■
Plumas	■		■	
Riverside	■	■ some zip codes ✱	■	■
Sacramento	■	■	■	■
San Benito	■			
San Bernardino	■	■ some zip codes ✱	■	■
San Diego	■	■ some zip codes ✱	■	■
San Francisco	■	■	■	■
San Joaquin	■	■	■	■
San Luis Obispo	■		■	■
San Mateo	■	■	■	■
Santa Barbara	■		■	■
Santa Clara	■	■ some zip codes ✱	■	■
Santa Cruz	■		■	■
Shasta	■		■	
Sierra	■		■	
Siskiyou	■			
Solano	■	■	■	■
Sonoma	■	■ some zip codes ✱	■ some zip codes ✱	■
Stanislaus	■	■	■	■
Sutter	■	■ some zip codes ✱	■	■
Tehama	■		■ some zip codes ✱	
Trinity	■		■ some zip codes ✱	
Tulare	■	■ some zip codes ✱	■ some zip codes ✱	■
Tuolumne	■			
Ventura	■	■ some zip codes ✱	■	■
Yolo	■	■ some zip codes ✱	■	■
Yuba	■	■ some zip codes ✱	■	■
Out of State	■			

Health Plan Rates Monthly

	City Health Plan	Kaiser	HealthNet	PacifiCare
Employee Only	$51.14	$0.00	$0.00	$0.00
Employee Plus One	$148.68	$87.85	$85.54	$83.37
Employee Plus 2 or More	$252.03	$160.76	$156.78	$153.81

Health Plan Rates Bi-Weekly

	City Health Plan	Kaiser	HealthNet	PacifiCare
Employee Only	$23.60	$0.00	$0.00	$0.00
Employee Plus One	$68.62	$40.55	$39.48	$38.48
Employee Plus 2 or More	$116.32	$74.20	$72.36	$70.99

DENTAL PLANS

An Overview Of The Different Types Of Dental Plans

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

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

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

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

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

No Changes To Any Of The Dental Plans This Year

COMPARISON OF DENTAL PLANS

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

PLAN NAME	DELTA DENTAL	PMI	PACIFIC UNION DENTAL
Provider of Service	Any licensed dentist. Generally higher benefits if you use Delta dentists.	Service is provided by PMI dentists only. You must live in the service area and you must choose your dentist from dentists contracting with the plan.	Service is provided by Pacific Union dentists only. You must live in the service area and you must choose your dentist from dentists contracting with the plan.
Cleanings and Exams	No charge. Limit once every six months.	No charge. Limit once every six months.	No charge. Limit once every six months.
X-rays	100%	No charge.	No charge.
Extractions	80%	$0-$70 copayment.	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.	$1,600 charge per case to age 19. $1,800 charge per case age 19 or older plus $350 start-up fee. Other limitations apply.	$1,660 charge per case through age 19. $1,880 charge per case age 20 or older. Other limitations apply.
Annual Maximum	$2,500 per person per benefit year, excluding orthodontic benefits.	None.	None.
Waiting Period	Six months for dentures, pontics, bridges and orthodontia for new enrollees.	None.	None.

SERVICE AREAS BY DENTAL PLAN

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

FLEXIBLE SPENDING ACCOUNTS

How The Flexible Spending Accounts Work

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

How Money Is Put Into Flexible Spending Accounts.

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

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

How You Get Money Back From Your Flexible Spending Accounts.

You will be reimbursed from your accounts when you submit eligible expenses to EBS. Claim forms for reimbursement are available from HSS and/or EBS. Although your expenses must be for services incurred from October 1 through September 30, you may file plan year claims until December 31. Any claims postmarked after December 31 **will not** be processed.

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

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

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

⇒ **You will forfeit any money left in your accounts after the end of the claim filing period,** so you should carefully figure out how much you want to set aside for each account. There are no exceptions to this rule.

⇒ **You cannot transfer money between the Health Care and Dependent Care accounts.**

⇒ **You cannot change the amounts you contribute into your Flexible Spending Accounts during the year unless the changes is on account of and consistent with a qualifying change in family status.**

⇒ **Expenses for services before or after the period for which you enroll are not eligible.** For example, a medical expense incurred in September is not eligible for reimbursement from a Health Care Account because your account is not open until October 1.

⇒ **Your expenses must meet the Internal Revenue Service (IRS) criteria.**

Health Care Flexible Spending Account

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

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

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

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

Health Care Account Worksheet

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

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

Dependent Day Care Flexible Spending Account.

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

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

◊ The amount you set aside cannot be more than your income or your spouse's income, whichever is less.

◊ If you and your spouse file separate tax returns, the most either of you may set aside is $2,500 a year.

◊ If your spouse goes to school full-time, you may set aside up to $2,400 a year if you have one eligible dependent and up to $4,800 a year if you have two or more eligible dependents.

◊ If your spouse also participates in a day care account at his or her workplace (or if your spouse is a City, School District or Community College District employee), the total amount you set aside to both Dependent Day Care Accounts cannot be more than $5,000.

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

◊ Your children under age 13, and

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

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

◊ Day care providers or companies who are paid for providing day care while you work. Social Security and unemployment taxes you pay for the provider are also eligible expenses. A day care provider cannot be your child under age 19 or anyone you claim as a dependent. **Note that you must give the name, address, and taxpayer identification number of the organization or person providing the day care.** If you do not give this information, the IRS may tax your Dependent Day Care Account.

◊ Nursery school expenses.

◊ That portion of the cost of private school or another institution that is for the cost of care beyond educational requirements (e.g. after school care).

◊ That portion of the cost of overnight camp that is for "day care" ("night care" expenses are not eligible).

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

For more information about eligible Health Care Account expenses, EBS using the contact information on the inside front cover.

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

Dependent Day Care Account Worksheet

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

1	**Total estimated eligible dependent day care expenses from July 1, 2000 through June 30, 2001, assuming you are enrolling in the account during Open Enrollment.**	**$________**
2	**Enter the appropriate amount from the chart below, or the amount on line 1, whichever is lower.**	**$________**
3	**Divide the number on line 2 by 26. This is the amount you should have deducted from each paycheck to cover your dependent day care expenses.**	**$________**

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

Adoption Assistance

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

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

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

There is also an income limitation on the amount of the deduction. If the total adjusted gross income for both parents (married or not) is $75,000 or less, the income limitation does not apply.

Qualified Adoption Expenses

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

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

Child with Special Needs

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

A "child with special needs" is any child if a state has determined that the child cannot or should not be returned to the home of his or her parents; the state has determined that there exists with respect to the child a specific factor or condition (such as his or her ethnic background, age, or membership in a minority or sibling group, or the presence of factors such as medical conditions or physical, mental, or emotional handicaps) because of which it is reasonable to conclude that the child cannot be placed with adoptive parents without providing adoption assistance; and the child is a citizen or resident of the United States, as defined in IRS Code Section 217(h)(3).

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

Adoption Tax Credit

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

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

Important Note:

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

Continuation Coverage For Separated Employees and Dependents (COBRA)

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

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

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

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

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

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

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

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

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

Health Plan COBRA Rates (Table D)

MONTHLY RATES	CITY HEALTH PLAN	KAISER	HEALTHNET	PACIFICARE
Employee	$309.10	$195.17	$192.28	$189.88
Employee + 1 Dependent	$524.65	$389.31	$381.32	$374.13
Employee + 2 or More Dependents	$753.06	$550.45	$538.75	$529.81

Dental Plan COBRA Rates (TABLE E)

MONTHLY RATES	DELTA	PMI	PACIFIC UNION DENTAL
Employee	$56.36	$22.61	$22.60
Employee + 1 Dependent	$92.62	$37.31	$37.32
Employee + 2 or More Dependents	$139.24	$55.17	$55.18

Frequently Asked Questions

The questions and answers in this section are general in nature. Contact EBS at (800) 229-7683 or the HSS Membership Division at (415) 554-1750 if you need help with your particular situation.

When may I enroll in these benefit plans?
You may enroll when you are hired as a permanent employee in a classification eligible to participate in the Management Cafeteria Plan or when you reach the six-month eligibility date for temporary employees. If you do not enroll at that time, you may only enroll during the annual Open Enrollment period.

What is an Open Enrollment period?
An Open Enrollment period is a period of time during which employees may change benefit plans and/or add or delete eligible dependents. The Open Enrollment period for 2000 is August 7 to August 25, 2000. The effective date of all Open Enrollment changes is October 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.

What is the effective date of my health and dental coverage?
Coverage for new permanent employees and their enrolled dependents starts on the first day of the pay period that begins after your first day of permanent employment. For example, if you begin work on June 1, and the next pay period begins June 15, you and your dependents will be covered from June 15 forward.

Coverage for temporary employees and their dependents begins on the first day of the pay period following the sixth month eligibility date, provided that you apply to HSS and EBS **before** the six month eligibility date.

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 no longer in the plan.

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

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

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

After 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 or EBS. You will be responsible for the entire amount of your contribution, whether it is taken out of your paycheck or not, so it is important to address this type of problem immediately.

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

Yes. You may maintain coverage by contacting EBS and making arrangements to pay any premium contributions due directly to HSS or other carriers.

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

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

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

Yes. The following dependents are eligible to enroll:

> 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:
>
> Dependent 1) is not married; 2) does not work full time; 3) continues 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 you income tax return.
>
> Children shall include your natural child, step-child 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

gas an exemption on your income tax. Documentation of dependency may be required.

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

When may I enroll an eligible dependent?
You may enroll eligible dependents at the time you originally enroll, within 30 days of a qualifying change in family status, or during the Management Cafeteria Plan 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 your home.

What is imputed income?
Imputed income is the taxable value of an employer-provided non-tax deductible fringe benefit under federal rules, 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.

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)

◊ change from full to part-time work or loss of 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 the MEA Open Enrollment period or if you have a qualifying change in family status. Coverage will end at the end of the pay period in which the application is filed.

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

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

Whose responsibility is it to notify HSS of a change in family status involving the addition or cancellation of a dependent?
It is your responsibility to make additions, cancellations or changes in your enrollment. You are, in most cases, the only person who is aware of any changes that occur in your family status requiring or permitting such additions, cancellation or changes.

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

In the event of my death, what happens to the coverage of my dependents?
Generally, surviving dependents of an employee may continue coverage in HSS after the death of an active or retired employee. If you die, your dependents should contact HSS immediately.

When do I lose coverage if I leave employment with the City?
When you leave City employment, except for retirement, your coverage and your dependents' coverage will cease on the last day of the pay period in which your termination occurs, unless you elect to continue coverage under HSS pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).
COBRA provides that employees who have terminated employment and their dependents are entitled to continue group coverage for a certain period by paying for the coverage at set rates. COBRA coverage will end at the earliest occurrence of: 1) coverage under another group plan; 2) failure to pay the contribution required under the benefit plan within thirty (30) days; or 3) the end of the applicable COBRA period. Coverage must be continuous.

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

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

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

What should I do if I have a membership grievance with HSS?
If you have a legitimate membership grievance which is not resolved to your satisfaction by HSS staff, you are entitled to appeal to the Health Service Board. You should submit your appeal to the Health Service Board as soon as possible, but no later than 90 days of the event which gave rise to your grievance. To appeal, send a letter stating that you wish to appeal and include the details of your problem, along with any documentation you wish the Health Service Board to review, to the Health Service System, Attention: Appeals, 1145 Market Street, Suite 200, San Francisco, CA 94103.