Important Notice

We are here to serve you...

Your satisfaction is very important to us. Should any questions arise regarding your insurance, please contact your agent. If you have additional questions, you may contact:

Group Department
Kansas City Life Insurance Company
PO Box 219425
Kansas City, MO 64121-9425
Telephone: 816-753-7000

If you are not satisfied...

If you are unable to obtain satisfaction from the agent or the company, you may write or call:

Consumer Services Division
California Department of Insurance
300 South Spring Street
Los Angeles, California 90013

Consumer Hotline: 1-800-927-HELP (1-800-927-4357)

10-Day Right to Examine Certificate

Please examine this certificate carefully. If you are not satisfied, you may return this certificate to us within 10 days of its receipt.

California Life and Health Insurance Guarantee Association Act Summary Document and Disclaimer

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guarantee Association ("CLHIGA"). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guarantee Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Association is not unlimited, as noted in the box below, and is not a substitute for consumers' care in selecting insurers.

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the Guarantee Association to induce you to purchase any kind of insurance policy.*

Policyholders with additional questions should first contact their insurer or agent or may then contact:

California Guarantee Association Life and Health Insurance P.O. Box 17319 Beverly Hills, CA 90209-3319	**or**	**Consumer Service Division California Department of Insurance 300 South Spring Street Los Angeles, CA 90013**

Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

Coverage

Generally, individuals will be protected by the California Life and Health Insurance Guarantee Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions from Coverage

However, persons holding such policies are not protected by this Guarantee Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract;
- Their policy was issued by a health care service plan (HMO, Blue Cross, Blue Shield), a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.

The Guarantee Association also does not provide coverage for:

- Unallocated annuity contracts; this is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals;
- Employer and association plans, to the extent they are self-funded or uninsured;
- Synthetic guaranteed interest contracts;
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate;
- Any portion of a contract that provides dividends or experience rating credits.

Limits on Amount of Coverage
The Act limits the Association to pay benefits as follow:

Life and Annuity Benefits
80% of what the life insurance company would owe under a life policy or annuity contract up to

- $100,000 in cash surrender values,
- $100,000 in present value of annuities, or
- $250,000 in life insurance death benefits.
- A maximum of $250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

Health Benefits
A maximum of $200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

Premium Surcharge
Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.

KANSAS CITY LIFE
INSURANCE COMPANY

Kansas City Life Insurance Company
Kansas City Missouri
(A stock insurance company)

Policyholder: City & County of San Francisco
Policy Number: AS0010701
Policy Effective Date: January 1, 2017

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and The Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

Secretary

President, CEO and Chairman

THIRTY DAY RIGHT TO EXAMINE CERTIFICATE
FOR CERTIFICATEHOLDERS 65 AND OVER

The Company urges you to examine this certificate closely. If you choose to cancel the certificate and return it for cancellation, by mail or other delivery method, within the 30-day examination period, the return shall void the certificate from the beginning, and the parties shall be in the same position as if a certificate had not been issued. All premiums paid shall be fully refunded to you by The Company in a timely manner.

A note on capitalization in this certificate:
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

CLASS 2

SHORT TERM DISABILITY COVERAGES

Table of Contents

Schedule of Insurance 3

Definitions 4

Eligibility and Enrollment 7

Period of Coverage 8

Benefits 10

Exclusions and Limitations 12

General Provisions 13

Schedule of Insurance

The Policy of Short Term Disability insurance provides You with short term income protection if You become Disabled from a covered Injury, Sickness or pregnancy. **Please refer to Your group enrollment form to see the Option that applies to You**.

The benefits described herein are those in effect as of January 1, 2017.

Cost of Coverage:
You must contribute toward the cost of coverage.

Eligible Class(es) For Coverage:
Class 2 - All Full-time Active Employees who are working in the Health Service system and not part of the Municipal Executive Association and who work at least 20 hours per week. The Class 2 employees must also be citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees.

Guaranteed Issue Weekly Benefit Amount: $700

Weekly Benefit: The lesser of:

- An amount You elect in increments of $25;
- 30% of your Pre-disability Earnings;
- 100% of Your Pre-disability Earnings minus Other Income Benefits; or
- $1,400

Minimum Weekly Benefit: $25

The **Maximum Duration of Benefits** for a Disability is:

1) when the Pre-existing Condition Limitation applies, 25% of the Weekly Benefit for up to 4 weeks; otherwise
2) 26 weeks if caused by Injury or Sickness.

Benefits Commence::

1) for Disability caused by Injury: on the 8th, consecutive day of Total Disability or Partial Disability;
2) for Disability caused by Sickness: on the 8th consecutive day of Total Disability or Partial Disability.

Annual Enrollment Period: as determined by Your Employer on a yearly basis.

Eligibility Waiting Period for Coverage

1) None - if You are Actively at Work for the Employer on the Policy Effective Date; or
2) 1st of the month following date of hire - if You start working for the Employer after the Policy Effective Date.

The number of days referenced above are continuous calendar days. The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time Active Employee with the Employer under the Prior Policy
.

Definitions

Actively at Work means You are performing the Substantial and Material Acts of Your Occupation for wage or profit:

1) in the usual way; and
2) for Your usual number of hours.

We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.

Active Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

Commissions means the weekly average of commissions You received from the Employer over:

1) the 24 month period ending immediately prior to the last day before You became Disabled; or
2) the total period of time You worked for the Employer, if less than the above period.

Current Weekly Earnings means Weekly earnings You receive from:

1) the Employer; and
2) Another employer with whom You became employed after Your Disability began.

Disability or Disabled means Total or Partial Disability or Totally or Partially Disabled.

Employer means the Policyholder.

Guaranteed Issue Amount means the amount of coverage for which We do not require Evidence of Insurability. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

Injury means physical harm or damage to the body which occurs while You are covered under The Policy. However, an Injury will be considered a Sickness if Your Disability begins more than 30 days after the date of the Injury.

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

Mental Retardation;
Pervasive Developmental Disorders;
Motor Skills Disorder;
Substance-Related Disorders;
Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
Narcolepsy and Sleep Disorders related to a General Medical Condition.

Other Income Benefits

means the amount of any benefit for loss of income, provided to You as a result of the period of Disability for which You are claiming benefits under this plan. This includes any such benefits that are paid to You or to a third party on Your behalf. This includes the amount of any benefit for loss of income from:

1) the United States Social Security Act, Civil Service Retirement System, the Railroad Retirement Act, the Jones Act, the Canada Pension Plan, the Quebec Pension Plan, or similar plan or act that You receive because of Your Disability;
2) the Veteran's Administration or any other governmental agency for the same Disability;
3) other than for the first 10 days from when Benefits Commence, salary continuation or sick pay;
4) the portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings;

Other Income Benefits also means the amount of any benefit for loss of income, provided to Your family from the United States Social Security Act, the Railroad Retirement Act, the Canada Pension Plan, the Quebec Pension Plan or similar plan or act that Your family receives as a result of the Disability for which You are claiming benefits under this plan.

You will not be required to claim any retirement benefits which You may only get on a reduced basis.

Any general increase in benefits required by law that You are entitled to receive under any Federal Law will not reduce the Short Term Disability Benefit payable for a period of Total Disability that began prior to the date of such increase.

If You are paid Other Income Benefits in a lump sum, We will pro-rate the lump sum:
1. over the period of time it would have been paid if not paid in a lump sum; or
2. if such period of time cannot be determined over a period of 24 months.

Partial Disability

means You are not Totally Disabled as a result of Sickness or Injury and, while actually working in an occupation, You are unable to engage with reasonable continuity in that or any other occupation in which You could reasonably be expected to perform satisfactorily in light of Your age, education, training, experience or station in life and physical and mental capacity.

Physician

means a person who is:

1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art recognized by Us; and
2) licensed to practice in the jurisdiction where care is being given; and
3) practicing within the scope of that license.

Pre-disability Earnings

means Your regular weekly rate of pay, including Commissions, not including Bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the date You were Actively at Work before You became Disabled.

Regular Care of a Physician

means that You are attended by a Physician, who is not related to You:

1) with medical training and clinical experience suitable to treat Your disabling condition; and
2) whose treatment is:
   a) consistent with the diagnosis of the disabling condition; and
   b) administered as often as needed.

Rehabilitative Employment

means employment or service which:

1) prepares a Disabled person to resume gainful work; and
2) is approved, in writing, by Us.

Your participation is voluntary.

Related

means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Definitions

Sickness means:

1) any condition, illness, disease or disorder of the body or mind;
2) any infection, except a pus-forming infection of an accidental cut or wound or bacterial infection resulting from an accidental ingestion of a contaminated substance;
3) hernia of any type unless it is the immediate results of an Injury covered by The Policy; or
4) pregnancy;
5) any disease of the heart;
6) Mental Illness;
7) Substance Abuse;
8) Any medical treatment for items (1) through (7) above.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances.

Substantial and Material Acts Means the acts that are normally required for the performance of Your Usual Occupation, that cannot reasonably be omitted or modified. To be at work for the number of hours in Your regularly scheduled workweek is also a Substantial and Material Act. However, to be at work in excess of 30 hours a week is not a Substantial and Material Act.

The Policy means the insurance contract which We issued to The Policyholder under the policy number shown on the face page.

Total Disability or Totally Disabled means that You are prevented by Injury or Sickness from performing with reasonable continuity the Substantial and Material Acts necessary to pursue Your Occupation in the usual or customary way. If You are in an occupation that requires You to maintain a license, Your failure to pass a physical examination required to maintain that license does not alone mean that You are disabled from Your Occupation.

We, Our, or Us means Kansas City Life Insurance Company.

Weekly Benefit means a weekly sum payable to You while You are Disabled, subject to the terms of The Policy.

Your Occupation or Your Usual Occupation means any employment, business, trade or profession and the substantial and material acts of the occupation You were regularly performing for Your Employer when the Disability began. Your Occupation is not necessarily limited to the specific job You are performing for a specific employer or at a specific location.

If You are a Physician or dentist, Your Occupation means the general or sub-specialty in which You are practicing for which there is a specialty or sub-specialty recognized by the American Board of Medical Specialties. If the sub-specialty in which You are practicing is not recognized by the American Board of Medical Specialties, You will be considered practicing in the general specialty category.

If You are an attorney, Your Occupation means the legal specialty or specialties in which You have practiced in the five year period preceding Your becoming Disabled. If You have been in legal practice for less than five years, Your Occupation means the legal specialty or specialties in which You have practiced in the period preceding Your Disability.

You or Your means the person to whom this certificate is issued.

Eligibility and Enrollment

Eligible Persons: *Who is Eligible for Coverage?*

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become Eligible?*

You will become eligible for coverage on the later of:

1) the Policy Effective Date; or
2) the date on which You complete the Eligibility Waiting Period for Coverage, if applicable.

See the Schedule of Insurance for the Eligibility Waiting Period for Coverage.

Enrollment: *How do I enroll for coverage?*

To enroll for coverage You must:

1) complete and sign a group insurance enrollment form which is satisfactory to Us; and
2) deliver it to the Employer.

You have the option to enroll electronically. Your Employer will provide instructions.

Any Enrollment may be subject to the Evidence of Insurability Requirements provision.

Evidence of Insurability Requirements: *When will I first be required to provide Evidence of Insurability?*

We require Evidence of Insurability for initial coverage, if You:

1) enroll outside of any Annual Enrollment Period and more than 31 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status;
2) enroll for a Weekly Benefit greater than the Guaranteed Issue Amount, regardless of when You enroll for coverage; or
3) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

If Your Evidence of Insurability is not approved by Us:

1) Your Weekly Benefit will equal the Guaranteed Issue Amount for which You were eligible, provided You enrolled within 31 days of the date You were first eligible to enroll or You enrolled during an Annual Enrollment Period; and
2) You will not be covered under The Policy if You enrolled outside of an Annual Enrollment Period and more than 31 days after the date You were first eligible to enroll.

Evidence of Insurability: *What is Evidence of Insurability?*

Evidence of Insurability may include, but will not be limited to:

1) a completed and signed application approved by Us;
2) a medical examination; and
3) any additional information and attending Physician's statements.

All Evidence of Insurability will be furnished at Your expense. We will then determine if You are insurable under The Policy.

Change in Family Status: *What constitutes a Change in Family Status?*

A Change in Family Status means:

1) You get married;
2) Your child is born or You adopt or become the legal guardian of a child;
3) Your spouse dies or You and Your spouse divorce;
4) Your child is emancipated or dies;
5) Your spouse is no longer employed, which results in a loss of group insurance; or
6) You have a change in classification from part-time to full-time or from full-time to part-time.

Period of Coverage

Effective Date: *When does my coverage start?*

Your coverage will start on the earliest of:

1) the first of the month following the date You become eligible, for benefit amounts not requiring Evidence of Insurability, if You enroll or have enrolled by then;
2) the first of the month following the date on which You enroll, for benefit amounts not requiring Evidence of Insurability, if You do so within 31 days after the date You are eligible;
3) the first of the month following the date We approve Your Evidence of Insurability, for benefit amounts requiring Evidence of Insurability; or
4) the first day of the month following the Annual Enrollment Period if You enroll, for benefit amounts not requiring Evidence of Insurability, during an Annual Enrollment Period.

Deferred Effective Date: *Will my coverage start or an increase in my coverage take effect if I am not Actively at Work on the date my coverage is to start or increase?*

If You are absent from work due to:

1) Injury; or
2) Sickness;

on the date Your insurance or increase in coverage would otherwise have become effective, Your insurance, or increase in coverage, will not become effective until You are Actively at Work one full day.

Changes in Coverage: Can I change my benefit option?

You may change Your benefit option only:

1) during an Annual Enrollment Period; or
2) within 31 days of a Change in Family Status.

At such time You may decrease coverage, or increase coverage to a higher option. An increase in coverage will be subject to Your submission of an application that meets Our approval.

When will a requested change in benefit option take effect?

If You enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the later of:

1) the first day of the month following the Annual Enrollment Period; or
2) the first of the month following the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.

If You enroll for a change in benefit option within 31 days following a Change in Family Status, the change will take effect on the later of:

1) the first of the month following the date You enroll for the change; or
2) the first of the month following the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.

Any such increase in coverage is subject to the following provisions:

1) Deferred Effective Date; and
2) Pre-existing Conditions Limitations.

Do coverage amounts change if there is a change in my class or my rate of pay?

Your coverage may increase or decrease on the date there is a change in Your class or Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:

1) are an Active Employee; and
2) are not absent from work due to being Disabled. If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.

Period of Coverage

What happens if the Employer changes the Policy?

Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, subject to the Deferred Effective Date provision.

Termination: *When will my coverage stop?*

Your coverage will end on the earliest of the following:

1) the date The Policy terminates;
2) the date The Policy no longer insures Your class;
3) the date premium payment is due but not paid;
4) the last day of the period for which You make any required premium contribution;
5) the date Your Employer terminates Your employment;
6) the date You cease to be a Full-time Active Employee in an eligible class for any reason;

unless coverage is extended under the Continuation Provisions.

Continuation Provisions: *Can my insurance be continued?*

Your coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

1) is subject to any reductions in the Policy;
2) is subject to payment of premium; and
3) terminates when the Policy terminates or coverage for Your class terminates.

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to 12 weeks, or longer if required by other applicable law, following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Coverage while Disabled: *Does my insurance continue while I am Disabled and no longer an Active Employee?*

If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

1) while You remain Disabled; and
2) until the end of the period for which You are entitled to receive short term Disability Benefits.

After short term Disability benefit payments have ceased, Your insurance will be reinstated, provided:

1) You return to work for one full day as a Full-time Active Employee in an eligible class;
2) The Policy remains in force; and
3) any required premiums for You were paid and continue to be paid.

Waiver of Premium: *Am I required to pay Premiums while I am Disabled?*

No premium will be due for You:

1) after the Benefits Commence period; and
2) for as long as benefits are payable.

Extension of Benefits for Disability: *Do my benefits continue if the Policy terminates?*

If You are entitled to benefits while Disabled and The Policy terminates, benefits:

1) will continue as long as You remain Disabled by the same Disability; but
2) will not be provided beyond the date We would have ceased to pay benefits had the insurance remained in force.

Termination of The Policy for any reason will have no effect on Our liability under this provision.

Disability Benefit: *When do I qualify for Disability Benefits?*

If, while covered under this Benefit, You:

1) become Disabled;
2) remain Disabled; and
3) submit Proof of Loss to Us;

We will pay the Weekly Benefit.

Calculation of Weekly Benefit: ***What happens if the sum of my Weekly Benefit, Current Weekly Earnings and Other Income Benefits exceeds 100% of my Pre-disability Earnings?***

If the sum of Your Weekly Benefit, Current Weekly Earnings and Other Income Benefits exceeds 100% of Your Pre-disability Earnings, We will reduce Your Weekly Benefit by the amount of the excess.

However, Your Weekly Benefit will not be less than the Minimum Weekly Benefit.

If an overpayment occurs, We may recover all or any portion of the overpayment, in accordance with the Overpayment Recovery provision.

Minimum Weekly Benefit: *Is there a Minimum Weekly Benefit?*

Your Weekly Benefit will not be less than the Minimum Weekly Benefit shown in the Schedule of Insurance.

Partial Week Payment: *How is a benefit calculated for a period of less than a week?*

If a Weekly Benefit is payable for less than a week, We will pay 1/7 of the Weekly Benefit for each day You were Disabled.

Recurrent Disability: *What happens to my benefits if I return to work as an Active Employee and then become Disabled again?*

When Your return to work as an Active Employee is followed by a Disability, and such Disability is:

1) due to the same cause; or
2) due to a related cause; and
3) within 15 consecutive calendar days of the return to work;

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force.

If You return to work as an Active Employee for 15 consecutive days or more, any recurrence of a Disability will be treated as a new Disability.

Period of Disability means a continuous length of time during which You are Disabled under The Policy.

Multiple Causes: *How long will benefits be paid if a period of Disability is extended by another cause?*

If a period of Disability is extended by a new cause while Weekly Benefits are payable, Weekly Benefits will continue while You remain Disabled, subject to the following:

1) Weekly Benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
2) any Exclusions and Pre-existing Conditions Limitations will apply to the new cause of Disability.

Termination of Benefit Payment: *When will my benefit payments end?*

Benefit payments will stop on the earliest of:

1) the date You are no longer Disabled;
2) the date You unreasonably fail to furnish Proof of Loss when requested by Us;
3) the date You are no longer under the Regular Care of a Physician;
4) the date You unreasonably refuse Our request that You submit to an examination by a Physician or other qualified medical professional;
5) the date of Your death;
6) the last day benefits are payable according to the Maximum Duration of Benefits;
7) the date Your Current Weekly Earnings are equal to or greater than 60 % of Your Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation; or
8) the date no further benefits are payable under any provision in The Policy that limits benefit duration.

Rehabilitative Employment Benefit: *What happens to my benefits if I accept Rehabilitative Employment?*

If, while You are Totally Disabled or Partially Disabled, You accept Rehabilitative Employment, We will continue to pay a Weekly Benefit.

The Weekly Benefit We will pay will be equal to Your Total Disability Weekly Benefit, less 50% of any income received from the Rehabilitative Employment.

The sum of the Weekly Benefit and total income received from Rehabilitative Employment may not exceed 100% of Your Pre-disability Earnings. If this sum exceeds the Pre-disability Earnings, the Weekly Benefit paid by Us will be reduced by the excess amount.

We reserve the right to review any Rehabilitative Employment You participate in while benefits are being paid under The Policy.

If You remain Disabled after a period of Rehabilitative Employment, You may continue to receive Disability benefits, subject to the Maximum Payment Period for such benefit.

Exclusions: *What Disabilities are not covered?*

The Policy does not cover, and We will not pay a benefit for any Disability:

1) that is caused or contributed to by war or act of war (declared or not);
2) caused by Your commission of or attempt to commit a felony;
3) caused or contributed to by Your being engaged in an illegal occupation;
4) caused or contributed to by an intentionally self-inflicted Injury;
5) caused or contributed to by Your active participation in a riot;
6) caused by Your voluntary election of a surgical procedure, except when required due to Injury or Sickness;
7) for which Workers' Compensation benefits are paid, or may be paid.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

1) was sponsored by the Employer; and
2) was terminated before the Effective Date of The Policy,

no benefits will be payable for the Disability under The Policy.

Pre-Existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*

We will pay benefits under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition or the medical or surgical treatment of a Pre-existing condition for a limited number of days as shown in the Schedule for any period of Disability beginning within the first 12 months of the effective date of Your coverage under this Policy.

You have a Pre-existing condition if:

1) You received medical treatment, care or services for a diagnosed condition or took prescribed medication for a diagnosed condition in the 12 months immediately prior to the effective date of coverage under this Policy; or
2) You suffered from a physical or mental condition, whether diagnosed or undiagnosed
    a. for which You received a physician's advice or treatment within 12 months before the date of Your coverage under this policy; or
    b. which caused symptoms within 12 months before the date of issue for which a prudent person would usually seek medical advice or treatment.

General Provisions

Notice of Claim: *When should I notify the Company of a claim?*

You must give Us in Kansas City, Missouri, or Our representative, notice of a claim within 20 days after Disability or loss occurs. If You cannot give notice within that time, You must give it to Us as soon as reasonably possible. Such notice must include Your name, Your address and the Policy Number.

Claim Forms: *Are special forms required to file a claim?*

We or Our representative will send forms to You to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, You may submit any other proof which fully describes the nature and extent of Your claim.

Proof of loss is typically provided by telephone; however, if forms are required, they will be sent to You for providing Proof of Loss within 15 days after We receive a notice of claim.

Proof of Loss: *When must proof of Disability be given?*

Proof of loss must be furnished to Us in Kansas City, Missouri in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Additional Proof of Loss: *What additional proof of loss are Wey entitled to?*

We may request proof of loss throughout your Disability. In such cases, We must receive the proof within 30 days of our request. At Our own expense, We shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as We may reasonably require during the pendency of a claim hereunder.

Claim Payment: *When are benefit payments issued?*

When You;

1) are Disabled; and
2) eligible to receive benefits;

We will pay accrued benefits at the end of each week that You are Disabled. We may make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid as soon as Proof of Loss is received.

Benefits are not payable for any period during which You are confined to a penal or correctional institution if the period of confinement exceeds 30 days.

Claims to be Paid: *To whom will benefits for my claim be paid?*

All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent;

then We may pay up to $1,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Claim Denial: *What notification will I receive if my claim is denied*

If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to the Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal:
What recourse do I have if my claim is denied?

On any claim, You or Your representative may appeal to Us for a full and fair review. To do so:

1) You must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) You may request copies of all documents, records, and other information relevant to Your claim; and
3) You may submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with Our final decision on the claim.

Other Income:
When must I apply for Other Income Benefits?

You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within 45 days from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

1) to follow the process established by the Social Security Administration to reconsider the denial; and
2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals if such action can reasonably be expected to result in an award.

If You are eligible for benefits under The Canadian Pension Plan, The Quebec Pension Plan, Railroad Retirement Act, or other similar government plan You will be required to apply for such benefits if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits You are eligible to receive with reasonable diligence.

If Your disability was caused by a work injury, You will be required to apply for Workers' Compensation benefits with Your employer if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits with reasonable diligence.

If You are eligible for benefits from California State Disability Insurance or disability insurance from another state, You will be required to apply for California State Disability Insurance or disability insurance from another state if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits with reasonable diligence.

We may require:

1. Your signed statement identifying all Other Income Benefits; and
2. proof that You and Your family have duly applied for all Other Income Benefits We reasonably believe You and Your family is entitled to or eligible to receive as a result of the Disability for which You are claiming benefits under this plan.

Benefit Estimates: *How does the Company estimate Disability benefits under the United States Social Security Act?*

We will Use any reasonable means to estimate the amount of Other Income Benefits payable under the Social Security Administration's Disability Income Program, the Canadian Pension Plan, The Quebec Pension Plan or any similar plan or act if We reasonably believe You or Your family are entitled or eligible to receive them but You or Your family have not applied; or failed to pursue them with reasonable diligence; or You have failed to provide Us with proof that You or Your family have applied for and reasonably pursued these benefits. We will deduct the estimated amount of this benefit from Your Weekly Benefit payable under this plan even if You or Your family are not receiving these benefits.

If We have reduced Your Weekly Benefit by an estimated amount, and:

1. You or Your family are later awarded Social Security disability benefits, We will adjust Your Weekly Benefit when We receive proof of the amount awarded; or
2. Your application for Social Security disability benefits has been denied, We will adjust Your Weekly Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If We have not reduced Your Weekly Benefit by an estimated Social Security disability benefit, We will adjust Your Weekly Benefit upon receipt of proof of the amount of Social Security disability benefits awarded.

If We owe You a refund, We will make such refund in a lump sum. If Your Weekly Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the provision entitled "How do We exercise the right to recover overpayments?"

Overpayment: *When does an overpayment occur?*

An overpayment occurs:

1) when total amount We have paid in benefits is more than the amount that was due to You under the Policy; or
2) when payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

1) retroactive awards received from sources listed in the Other Income Benefits definition;
2) failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;
3) misstatement;
4) fraud; or
5) any error We may make.

Overpayment Recovery: *How do We exercise the right to recover overpayments?*

We have the right to recover from You any overpayment amount. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under this Policy.

If benefits are overpaid on any claim, You must reimburse Us within 30 days.

If reimbursement is not made in a timely manner, We have the right to:

1) recover such overpayments from:
   a) You;
   b) any other organization;
   c) any other insurance company;
   d) any other person to or for whom payment was made; and
   e) Your estate.
2) refer Your unpaid balance to a collection agency; and
3) pursue and enforce all legal and equitable rights in court.

Legal Actions: *When can legal action be taken against Us?*

Legal action cannot be taken against Us:

1) sooner than 60 days after the date proof of loss is given; or
2) 3 years after the date Proof of Loss is required to be given according to the terms of The Policy.

Fraud: *How does the Company deal with fraud?*

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Misstatements: *What happens if facts are misstated?*

If material facts about You were not stated accurately:

1) Your premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

How We determine Your eligibility for benefits.

We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility for benefits for any claim You make on The Policy. We will:

1) obtain, with Your cooperation and authorization if required by law, only such information that is necessary to evaluate Your claim and decide whether to accept or deny Your claim for benefits. We may obtain this information from Your Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your option and at Your expense, You may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your choice. You should provide Us with all information that You want Us to consider regarding Your claim;
2) consider and interpret The Policy and all information obtained by Us and submitted by You that relates to Your claim for benefits and make Our determination of Your eligibility for benefits based on that information and in accordance with the Policy and applicable law;
3) if We approve Your claim, We will review Our decision to approve Your claim for benefits as often as is reasonably necessary to determine Your continued eligibility for benefits;
4) if We deny Your claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with the Policy as described in the provision entitled "What notification will You receive if Your claim is denied?"

In the event We deny Your claim for benefits, in whole or in part, You can appeal the decision to Us. If You choose to appeal Our decision, the process You must follow is set forth in The Policy provision entitled "What recourse do You have if Your claim is denied?" If You do not appeal the decision to Us, then the decision will be Our final decision.

The Following Important Notice is Provided by Your Employer for your Information Only.

For the purpose of meeting certain requirements of the Employee Retirement Income Security Act of 1974, the following information and the attached Claim Procedures and Statement of ERISA Rights are provided for use with your certificate to form the Summary Plan Description.

The benefits described in your certificate are provided under a group plan by the Insurance Company and are subject to the terms and conditions of that plan.

A copy of this plan is available for your review during normal working hours in the office of the Plan Administrator.

---

1. **Plan Name**

   Group Plan for employees of City & County of San Francisco

---

2. **Plan Number**

   N/A

---

3. **Employer/Plan Sponsor**

   City & County of San Francisco
   1145 Market Street, 3rd Floor
   San Francisco, CA 94103

---

4. **Employer Identification Number**

   94-6000417

---

5. **Type of Plan**

   Welfare Benefit Plan providing Group Disability benefits

---

6. **Plan Administrator**

   City & County of San Francisco
   1145 Market Street, 3rd Floor
   San Francisco, CA 94103

---

7. **Agent for Service of Legal Process**

For the Plan:
City & County of San Francisco
1145 Market Street, 3rd Floor
San Francisco, CA 94103

For the Policy:
Kansas City Life Insurance Company
3520 Broadway
Kansas City, MO 64111

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

---

8. **Sources of Contributions** -- The Employee pays the premium for the insurance.

---

9. **Type of Administration** -- The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

---

10. The Plan and its records are kept on a Policy Year basis.

---

11. **Labor Organizations**

None

---

12. **Names and Addresses of Trustees**

None

---

13. **Plan Amendment Procedure**

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

Statement of ERISA Rights

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1) Receive Information About Your Plan and Benefits:

   a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

   b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

   c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

2) Continue Group Health Plan Coverage:

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuous coverage rights.

3) Prudent Actions by Plan Fiduciaries:

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

4) Enforce Your Rights:

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5) Assistance with Your Questions:

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Adm9inistration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Claim Procedures for Disability Income Insurance Plans

1) Claims for Benefits:

If you would like to present a claim for benefits for yourself or your insured dependents, you should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) should be completed by (1) you, (2) the Employer or Administrator and (3) the Attending Physician or hospital.

Following completion, the claim form(s) must be forwarded to the individual authorized to evaluate claims (Administrator or Insurance Company's Claim Representative). The individual authorized to evaluate claims will determine if benefits are payable and, if due, issue payment(s) to you.

The Insurance Company will make a decision no more than 45 days after receipt of your claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request.

The written decision will include: 1) specific reasons for the decision, 2) specific references to the plan provisions on which the decision is based, 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, 4) a description of the review procedures and time limits applicable to such procedures, 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal, and, 6)(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

2) Appealing Denial of Claims:

On any wholly or partially denied claim, you or your representative may appeal to us for a full and fair review. You may:

a) request a review upon written application within 180 days of the claim denial;

b) request, free of charge, copies of all documents, records, and other information relevant to your claim; and

c) submit written comments, documents, records and other information relating to your claim.

The Insurance Company will make a decision no more than 45 days after we receive your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request. The written decision will include specific references to the plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.