

Open Enrollment Flexible Credit Allocation

Each year MEAs are allocated a dollar value in credits that they can apply to a variety of pre- and post-tax benefit options. You must allocate your flexible credits for 2010-2011 during April 2010!

To make annual flexible credit benefit allocations more convenient for you, EBS has streamlined the process. During this year's Open Enrollment, which takes place April 1 through April 30, 2010, Employee Benefits Specialists (EBS) now offers three flexible credit allocation options. Any change you make to your credit allocations in April will be effective July 1, 2010. Note: If you do not complete your flexible credit allocation with EBS during April 2010 Open Enrollment, your credits will be automatically distributed as of July 1, 2010.

Option 1: If you are not making any changes to your flexible credit allocations

Mail/Fax Flexible Credit Allocation

Review the 2010/11 election form that will be sent to you by EBS at the end of March. This form indicates what your allocations will be if you roll over your current flexible credit choices to the next plan year. If you are not making any changes, sign, date, and fax this election form to EBS. The EBS fax number is (925) 460-3920. Save the fax receipt as your confirmation. In this case, no telephone or in-person appointment with EBS is required!

Option 2: If you are changing your flexible credit allocations

Mail/Phone/Fax Flexible Credit Allocation

Review the 2010/11 election form that will be sent to you by EBS at the end of March. This form indicates what your allocations will be if you roll over your current flexible credit choices to the next plan year. If you would like to make changes to the allocation choices listed on the election form, call EBS at (888) 327-2770 and schedule a phone conference with an EBS representative. In most cases, no in-person appointment with EBS will be required. After the scheduled phone conference, EBS will mail you an updated election form reflecting the changes you requested. Upon receipt, sign and date the revised election form and any additional required documents. Return these documents via fax or mail as required by EBS.

Option 3: If you prefer an in-person appointment with an EBS representative

In-Person Appointment Flexible Credit Allocation

A limited number of in-person EBS appointments will be available at the Health Service System office and the Airport in April 2010. If you would like to schedule an in-person appointment to review your flexible credit allocations for plan year 2010-2011 call EBS today at (888) 327-2770.

MEAs and unrepresented managers can help the City of San Francisco reduce administrative costs by working with EBS to complete flexible credit allocations early. Please allocate your credits by April 16, 2010 so we can reduce the time required to process MEA allocations!

Flexible Credits

Dollar Value of Credits

In lieu of dependent coverage subsidized by the City, MEA and unrepresented managers are allocated a dollar value in credits that they can apply to a variety of pre- and post-tax options. In 2010-2011, eligible **City and County of San Francisco enrollees** will receive **\$329.85** in credits **twice monthly** to purchase from the options listed on page 25. Eligible **Superior Court enrollees** will receive **\$620.75** in credits **twice monthly** to purchase from the options listed on page 25.

Initial Enrollment

Eligible employees may allocate available flexible credits to any combination of available pre- or post-tax benefit options based on the actual cost of each benefit. Enrollment is handled through EBS.

Flexible credit allocation options include putting credits toward employee contributions to health insurance premiums. If 100% of flexible credits are applied toward employee health premium contributions and the cost of the required contribution exceeds the total credits available, the additional amount will be covered by twice monthly payroll deduction.

Credits applied to post-tax benefits will result in imputed income.

Denied Coverage

Members who allocate flexible credits toward an insurance benefit but are then denied coverage may elect one of the following:

- The member may reallocate 100% of the flexible credit amount that was allocated to the denied benefit option(s) to the Miscellaneous Reimbursement option. (Imputed income will be calculated.)

OR

- The member may elect to forfeit 100% of the flexible credit amount that was allocated to the denied benefit option(s) for the duration of the plan year.

Members who elect to reallocate flexible credits to the Miscellaneous Reimbursement option will not receive the retroactive value of the applicable flexible

credits but will have the applicable amount applied to the Miscellaneous Reimbursement account on a prospective basis.

Miscellaneous Reimbursement

If you allocate credits to Miscellaneous Reimbursement you must provide proof of qualifying expenses incurred between July 1, 2010 and June 30, 2011 to EBS by September 30, 2011. All options with no payroll deduction require paper claim forms and proof of expenditures to be filed directly with EBS for reimbursement. Download claim forms at myhss.org.

Miscellaneous Reimbursement Forfeiture

If you elect to allocate credits toward Miscellaneous Reimbursement but do not submit sufficient eligible claims to EBS against your credits by the required deadlines you will forfeit those flexible credit dollars.

Family Status Changes

Members may only elect to reallocate flexible credits if the reallocation relates directly to a qualified change in family status. (See pages 32-33.)

Open Enrollment

Members must allocate flexible credits annually during Open Enrollment. Call EBS at (888) 327-2770.

Any member who does not take action to make a flexible credit allocation during Open Enrollment will be subject to the following:

- If the member currently has medical plan coverage through Kaiser, Blue Shield or City Plan, flexible credits for the 2010-2011 Plan Year will be automatically applied to the actual cost of the medical plan at the same level of coverage currently in place. Any additional amount required to cover the actual cost of the medical plan will be covered by payroll deductions. All remaining credits, if any, will be allocated to the Miscellaneous Reimbursement Account and subject to imputed income.
- If the member currently has no medical plan coverage, all credits will be allocated to the Miscellaneous Reimbursement Account and subject to imputed income.

Flexible Credit Options Summary

Contact EBS at (888) 327-2770 for information about how to allocate flexible credits.

PRE-TAX FLEXIBLE CREDIT OPTIONS

	Tax Status	Flexible Credit	Payroll Deduction
Employee Health Premium Contributions	Pre-Tax	Yes	Yes
Healthcare Flexible Spending Account FBMC	Pre-Tax	Yes	Yes
Dependent Care Flexible Spending Account FBMC	Pre-Tax	Yes	Yes
Cancer Insurance Allstate Workforce Division	Pre-Tax	Yes	Yes
Heart and Stroke Insurance Allstate Workforce Division	Pre-Tax	Yes	Yes
Accident Insurance Allstate Workforce Division	Pre-Tax	Yes	Yes
Long Term Disability Insurance UNUM	Pre-Tax	Yes	No

POST-TAX FLEXIBLE CREDIT OPTIONS

	Tax Status	Flexible Credit	Payroll Deduction
Universal Life Insurance ING	Post-Tax	Yes	Yes
Short Term Disability Insurance ING	Post-Tax	Yes	Yes
Long Term Care Insurance MetLife	Post-Tax	Yes	Yes
Pet Insurance PetCare	Post-Tax	Yes	Yes
Group Legal Plan Pre-Paid Legal	Post-Tax	Yes	Yes
Supplemental Group Term Life Insurance Reliastar \$50,000 Group Term Life Insurance provided at no cost to all employees eligible for flexible credit benefits.	Post-Tax	Yes	No
Commuter Transit Reimbursement EBS Note: a separate pre-tax Commuter Check benefit administered by FBMC is also available to all City employees.	Post-Tax	Yes	No
Miscellaneous Reimbursement Account Submit receipts to EBS for qualifying expenses, including: <ul style="list-style-type: none"> • MEA dues • Auto insurance • Prior service buyback • Professional coaching • Tuition reimbursement when an employee has exceeded the \$2,000 allocation from the MEA training fund. • Memberships or tickets to cultural events at institutions funded or operated by the City of San Francisco Hotel Tax Fund. Visit myhss.org for details about these and other qualifying expenses. Note: Contributions to 457(b) deferred comp accounts do not qualify.	Post-Tax	Yes	No

Flexible Spending Accounts

An FSA is an IRS-approved tax favored account you can use to pay for eligible medical and dependent care expenses not covered by insurance. Funds are set aside from your salary pre-tax.

How an FSA Works

Flexible Spending Accounts (FSAs) let you set aside money pre-tax to pay for eligible healthcare and/or dependent care expenses. You can enroll in either a Healthcare FSA, a Dependent Care FSA or both.

It is possible to realize tax savings with an FSA—but keep in mind that any unused FSA dollars at the end of the year will be forfeited according to IRS rules. So you need to plan ahead to make the most of an FSA. To calculate potential FSA tax savings, visit myfbmc.com/ccsf and click on the tax calculator. You should also consult your tax adviser or the IRS for information about your specific situation.

The following information provides an overview of your FSA benefits. To get details about this benefit contact FBMC, the FSA administrator, or visit myfbmc.com/ccsf. You can also request an FSA resource guide from HSS Member Services.

Healthcare FSA

- Set aside from \$120 up to \$5,000 pre-tax per household in a Plan Year. Depending on the annual amount that you elect, deductions of between \$5.00 and \$208.33 will be taken twice monthly from your paycheck in Plan Year 2010-2011. No deduction is taken from the 3rd paycheck in any month.
- Submit reimbursement forms to FBMC for eligible out-of-pocket expenses, including healthcare deductibles, prescriptions, over-the-counter medical items and more for you and eligible dependents.
- When you sign-up for a Healthcare FSA the total annual amount you designate becomes available for eligible healthcare expenses at the start of the Plan Year. You do not have to wait for your contributions to accumulate in your account.

Dependent Care FSA

- Set aside from \$120 up to \$5,000 pre-tax per household in a Plan Year. Deductions will be taken twice monthly from your paycheck throughout Plan Year 2010-2011. Depending on the annual amount that you specify, deductions of between \$5.00 and \$208.33 will be taken twice monthly from your paycheck in 2010-2011. No deduction is taken from the 3rd paycheck in any month.
- If you have a stay-at-home spouse, you should not enroll in the Dependent Care FSA.
- Submit reimbursement forms to FBMC for eligible out-of-pocket expenses, such as certified day care, pre-school and elder care for your qualifying dependents.
- The funds for a Dependent Care FSA are available after they have been deducted from your paycheck and received by FBMC. Unlike a Healthcare FSA, the entire annual amount for a Dependent Care FSA is not available at the start of the Plan Year.

Estimating FSA Expenses

Before enrolling in an FSA make sure to work out a detailed estimate of the eligible expenses you are likely to incur for the year ahead. Budget conservatively. Any unreimbursed funds are forfeited at the end of the Plan Year and cannot be returned to you. You can find FSA calculation tools on myfbmc.com. For a list of eligible expenses, the definition of qualifying family members and how to submit reimbursements, visit myfbmc.com/ccsf. FSA expenses must meet Internal Revenue Service (IRS) eligibility criteria. Please refer to IRS publications 502 and 503: irs.gov/pub/irs-pdf/p502.pdf and irs.gov/pub/irs-pdf/p503.pdf.

FSA Administrator FBMC

The Flexible Spending Account benefit is administered by FBMC. Visit myfbmc.com/ccsf or call (800) 865-3262 on Monday-Friday, 4 AM-7 PM Pacific Time to get detailed information about your FSA.

- Learn more about FSAs.
- View a list of eligible expenses.
- Review the status of your reimbursement requests.
- Review your account balance and available funds.
- Download reimbursement forms.

Direct Deposit Reimbursement

To apply, complete the Direct Deposit Enrollment Form on myfbmc.com/ccsf or contact FBMC Customer Service at 1-800-342-8017. Processing your Direct Deposit enrollment may take four to six weeks.

- After your reimbursement claim is reviewed and approved, reimbursement funds are deposited into your checking or savings account.
- There is no fee for this service.
- You don't have to wait for postal service delivery of your reimbursement. (However, you will receive notification that the claim has been processed.)

Annual Re-enrollment Required

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

No Transferring Between Accounts

You cannot transfer money between Healthcare and Dependent Care Flexible Spending Accounts.

Changing Contribution Amounts

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

Termination or Retirement

If your employment ends during the Plan Year, you can only file claims for FSA eligible expenses that were incurred while you were actively employed.

Leaves of Absence

During an unpaid leave of absence, no deductions can be taken for an FSA if paychecks are not issued. Also, FSA claims cannot be filed for qualifying expenses incurred while an employee was on leave. Accounts that remain unpaid for three consecutive pay periods will be terminated retroactively to the first missed pay period. You may only reinstate your Flexible Spending Account upon your return to work by contacting HSS and requesting a reinstatement. At that time you have the option of making up the contributions that were missed due to your leave.

Eligibility Time Period

Expenses for services incurred before July 1, 2010 or after June 30, 2011 are not eligible for reimbursement. For example, a medical expense incurred in June 2010 isn't eligible for reimbursement from a Healthcare Flexible Spending Account because your account is not open until July 1, 2010.

Avoid Forfeiting FSA Contributions

FSA expenses for Plan Year 2010-11 must be incurred between July 1, 2010 and June 30, 2011. Claims must postmarked no later than September 30, 2011. Per IRS rules, you will forfeit any money left in your FSA(s) after the end of this claim filing period.

There are no exceptions.

Group Term Life Insurance

administered by Reliastar

Group term life insurance is coverage purchased by or through an employer for a group of employees. With life insurance, in return for premium payments, the insurer agrees to pay a sum of money to designated beneficiaries when an insured individual dies.

\$50,00 Employer Provided Group Term Life Insurance

All employees who are eligible to participate in the Management Cafeteria Plan are provided a \$50,000 group term life insurance policy for themselves at no cost. Because this benefit is paid for by your employer, this \$50,000 policy is not portable if you are separated from City employment.

Supplemental Group Term Life Insurance Coverage

Eligible employees can purchase additional group term life insurance for themselves to supplement the \$50,000 plan paid for by the City. When considering how much life insurance protection you need, consider:

- Who relies on your income for financial security?
- Do you have children who will need financial protection?
- Would your parents need to find another source to replace financial support that you currently give them?

Supplemental Coverage Is a Post-Tax Flexible Credit Option

The Internal Revenue Service (IRS) limits the total amount of tax-free life insurance you may receive from your employer and purchase for yourself under a group term plan to \$50,000. Any coverage you purchase in addition to the \$50,000 group term life plan paid for by your employer must be paid for with your post-tax flexible credits.

Beneficiary Designation

With all life insurance policies, if you designate a beneficiary (such as a spouse or domestic partner) and your personal circumstances change (i.e. divorce) your beneficiary will remain the same unless you request a change.

If you do not have a life insurance beneficiary designation on file, your beneficiaries will follow current law: surviving spouse, then surviving children, then surviving parents. If none of these family members survive you, benefits will be paid to your estate. To update your beneficiary information contact EBS at (800) 229-7683 to request a form.

Supplemental Group Life Insurance Coverage Amounts

Eligible members may elect to purchase additional amounts of term life insurance coverage for themselves in amounts ranging from \$10,000 to \$300,000 in increments of \$10,000. Flexible credits allocated toward supplemental life insurance coverage are after-tax amounts. There is a maximum \$50,000 guarantee issue for new employees. All amounts over \$50,000 or coverage elected after 31 days of initial eligibility require evidence of insurability.

Sample Twice Monthly Premium Calculation For Supplemental Coverage

You can determine the twice monthly premium you will pay on an after tax basis by following the steps shown in the example below:

Sally is 45 years old and earns \$80,000 per year. She chooses to purchase two times her annual salary. (Remember Sally has \$50,000 of coverage provided to her by her employer at no cost.)

Step 1: $\$80,000 \times 2 = \$160,000$

Step 2: $\$160,000 \div \$10,000 = 16$

Step 3: $16 \times \$1.05 = \16.80 twice monthly cost

RELIASTAR SUPPLEMENTAL GROUP TERM LIFE INSURANCE POST-TAX RATES	
Age	Twice Monthly Pay Period Cost per \$10,000
< 30	\$.34
30-34	\$.38
35-39	\$.48
40-44	\$.67
45-49	\$1.05
50-54	\$1.71
55-59	\$2.85
60-64	\$4.47
65-69	\$7.70
70-74	\$13.68
75+	\$22.99

Universal Life Insurance

a post-tax flexible credit option, administered by ING

This program allows you to apply for a life insurance policy for yourself to supplement the \$50,000 individual life insurance policy that is paid for by your employer. You can also apply for individual life insurance policies for your spouse or domestic partner, and dependent children, even if you choose not to apply for your own policy.

This information is a brief description of coverage and is not your contract. Read your policy and riders carefully for exact terms and conditions. For more information call EBS at (888) 327-2770.

Policy Design Highlights

- Individual, employee-owned policy
- Life insurance protection
- Tax-deferred cash value accumulation (based on current tax laws)
- Interest on accumulation value credited daily
- Cash value loans
- Partial withdrawal privileges
- Payable to age 100
- Unisex rates
- Tobacco and No Tobacco rates (for ages 18 years through 70); Standard rates (for ages 15 days through 17 years).

With this policy you can:

- Apply for individual life insurance policies for your spouse and dependent children, even if you choose not to apply for your own policy.
- Select the premium amount or the amount of the death benefit that meets your needs.
- Change your selections in the future during the annual open enrollment as your needs change.
- Pay required premiums using a post-tax payroll deduction as long as you are employed by the City.
- Take the policy with you if you separate from City employment. ING, the insurance carrier, will bill you directly.

Take note:

- Changes in the current non-guaranteed interest rate, current cost of insurance rates, and current expense charges are declared by the insurance company's board of directors and will affect the cash value. The current non-guaranteed interest rate will never be less than the guaranteed interest rate that is shown in your policy booklet.
- An increase in the amount of insurance may require evidence of insurability and will be rated at the age you are when you increase the death benefit.
- Once cash value accumulates, you can borrow against it at the rate shown in your policy. Interest is payable in advance. The death benefit will be reduced by the amount of any outstanding loan and unpaid accrued interest.
- To keep you informed, a report showing policy activity is sent annually. This report lists all the transactions, such as premium payments, loans, and withdrawals as well as interest, policy expenses, and policy values.

Simplified Issue Plan Eligibility

Newly hired employees may apply for up to three times their annual salary, up to \$100,000 (defined benefit), or purchase a benefit amount determined by pricing premiums up to \$14 per week (money purchase). The benefit amount cannot exceed three times annual salary. No physical will be required for new hires only, if applying within these parameters. Simplified Issue eligibility requirements include full-time employees who are actively at work and are between 15 and 70 years of age. Satisfactory responses to required application questions regarding health status are required.

Application Questions For New Hires

- During the past 12 months, have you missed 5 or more consecutive work days because of sickness or injury?
- Has the Proposed Insured used tobacco in any form in the last 24 months? Respond if 18 years of age or older.

Universal Life Insurance

- Has the Proposed Insured been diagnosed and/or treated by a member of the medical profession for positive HIV or AIDS?
- Is the Insurance now applied for intended to replace, in whole or in part, any insurance or annuities on the life of the Proposed Insured?

Application Questions For New Applicants Who Are Not Newly Hired

- Has the Proposed Insured been hospitalized in any medical facility or nursing home, as either an in or out patient, within the past 90 days?
- Has the Proposed Insured in the last years been diagnosed and/or treated by a member of the medical profession for positive HIV or AIDS?
- Is the Insurance now applied for intended to replace, in whole or in part, any insurance or annuities on the life of the Proposed Insured?
- What is your height and weight?
- In the last 5 years, has the Proposed Insured been treated or diagnosed for any heart trouble, stroke, or cancer?
- Has the Proposed Insured had or been treated for: disease or disorder of the heart, lungs, nervous system, liver, kidneys, colon or genitor-urinary system; stroke; high blood pressure; cancer or tumors; arthritis; diabetes; alcohol or drug use?
- Has the Proposed Insured consulted any physicians or surgeons in the last 5 years for any reason, including physical examinations?

If you answered “Yes” to any of the questions above, be prepared to give your enrollment representative your doctor’s name, address and phone number, as well as your medical history, including medications you have taken in the past and are currently taking.

Spouse/Domestic Partner Eligibility

Your spouse or domestic partner is eligible to apply for insurance by meeting certain eligibility requirements, even if you choose not to apply for insurance for yourself. Contact EBS for details.

Child Eligibility & Coverage

Your unmarried, dependent children and dependent grandchildren ages 15 days through 24 years, are eligible to apply for a \$25,000 individual universal life insurance policy by meeting certain eligibility requirements. (Children age 18 – 24 must be present to sign the application. Contact EBS for details.) Age restrictions and coverage limits may vary in some states.

A child’s term life insurance rider, available in coverage amounts of \$2,000 through \$10,000, can be attached to either your policy or your spouse’s/domestic partner’s policy. This rider covers all of your dependent children age 15 days through 24 years. On the policy anniversary date after a child reaches his or her 25th birthday, the term insurance rider can be converted to an individual Universal Life policy for up to five times the term coverage and without evidence of insurability. The new policy can be converted to a life insurance policy offered by ING at the time of conversion and must be for at least the minimum amount issued for the policy selected.

Important: Read Your Policy

These are plan highlights—not a contract. If these highlights and the policy differ, the policy will govern. Questions? Call EBS at (800) 229-7683.

Universal Life Insurance

a post-tax flexible credit option, administered by ING

Available Benefit Riders

Accelerated Benefit Rider (ABR)

Pays the policy owner up to 50% of the available death benefit if an insured is diagnosed as having fewer than 12 months to live. Advance payments are treated as policy liens with interest charged. The advanced payment cannot be less than \$10,000.

This rider is automatically included on all policies, including dependent children unless prohibited by state regulations.

Accidental Death Benefit Rider (ADB)

Provides an additional benefit if the insured dies as the result of an accident, as defined in the policy. This rider is available to employees and spouses/domestic partners only. This rider pays a benefit equal to twice the policy face amount if the accident occurs in a common carrier.

Children's Term Insurance Rider (CTR)

This benefit provides term insurance on dependent children age 15 days through 24 years for amounts ranging from \$2,000 to \$10,000 (\$1,000 increments). This rider can be included on either an employee's policy or spouse's policy provided the employee or spouse is under the age of 61.

Waiver of Monthly Deduction Rider (WMD)

Designed to offer continued insurance protection if the insured becomes disabled, according to the policy terms for four months. WMD is available to employees under age 55 only.

Premier Universal Life Insurance Rates

Important: The rates shown below are for illustrative purposes only. Your actual rate will be determined at the time of your enrollment. The sample scenarios listed below represent the value of an employee only, no tobacco policy with the WMD Rider.

Issue Age	Insurance Amount	Cash Value
		at age 65 Non-Guar. 5.1%*
25	\$138,676	\$29,627
30	\$112,519	\$19,776
35	\$86,660	\$13,305
40	\$68,244	\$10,635
45	\$50,473	\$ 8,757
50	\$35,073	\$ 5,703
55	\$25,154	\$ 3,329
60	\$21,148	\$ 3,235
65	\$14,362	\$ 3,656
70	\$10,162	\$ 3,545

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

Issue Age	Twice Monthly Premium	Cash Value
		at age 65 Non-Guar. 5.1%*
25	\$11.90	\$ 9,205
30	\$14.30	\$ 7,813
35	\$18.25	\$ 7,203
40	\$22.62	\$ 7,553
45	\$30.05	\$ 8,661
50	\$42.62	\$ 8,297
55	\$58.80	\$ 6,824
60	\$69.66	\$ 7,940
65	\$101.88	\$13,285
70	\$143.35	\$18,383

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

Universal Life Insurance

Premier Universal Life Insurance for Dependent Children and Grandchildren*

Both tobacco and no tobacco rates are available for issue ages 18 through 24. No tobacco premiums are available for ages 18 through 24 years if the proposed insured has not used tobacco in any form in the last 24 months (two years).

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

Issue Age	Twice Monthly Premium		Cash Value at Age 65 (Non-Guar. 5.1%*)	
	\$25,000 Standard Rates			
0		\$5.05		\$17,905
1		\$5.10		\$17,306
2		\$5.14		\$16,560
3		\$5.18		\$15,825
4		\$5.25		\$15,268
5		\$5.31		\$14,695
6		\$5.38		\$14,110
7		\$5.42		\$13,358
8		\$5.51		\$12,946
9		\$5.59		\$12,518
10		\$5.66		\$11,936
11		\$5.75		\$11,529
12		\$5.83		\$11,086
13		\$5.92		\$10,649
14		\$6.00		\$10,245
15		\$6.11		\$ 9,935
16		\$6.20		\$ 9,950
17		\$6.35		\$ 9,074
	\$25,000 No Tobacco	\$25,000 Tobacco	\$25,000 CV No Tobacco	\$25,000 CV Tobacco
18	\$5.68	\$6.72	\$5,647	\$ 5,039
19	\$5.68	\$7.54	\$5,073	\$ 7,679
20	\$5.75	\$8.43	\$4,802	\$10,666
21	\$5.88	\$8.76	\$4,784	\$10,568
22	\$6.03	\$9.08	\$4,811	\$10,419
23	\$6.18	\$9.28	\$4,806	\$10,055
24	\$6.35	\$9.62	\$4,853	\$ 9,898

Premier Universal Life Insurance for Available Dependent Rider

Children's Term Insurance Rider

Insurance Amt	Twice-Monthly Premium
\$ 5,000.....	\$1.52
\$ 7,000.....	\$2.12
\$ 9,000.....	\$2.73
\$10,000.....	\$3.03

All non-guaranteed cash value potential policy values shown assume that the currently illustrated non-guaranteed elements will continue unchanged for all years shown. This is not likely to occur, and actual results may be more or less favorable than those shown

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

Short Term Disability Insurance

a post-tax flexible credit option administered by ING

Short term disability insurance can help safeguard your income if you experience a prolonged sickness or injury. This insurance coverage is available to employees only; dependents are not eligible.

During your initial enrollment period (newly hired employees only), this coverage is available to you on a guaranteed issue basis, within income replacement guidelines, as long as you are currently active at work on a full-time or part-time basis. If you sign up at a later date or add an additional benefit amount, medical underwriting may be required.

Policy Design Highlights

Full Disability Benefit Payments

Coverage provides benefit payments from \$300 to \$5,000 based on income replacement guidelines for covered disabilities. Disabilities lasting less than one month will be paid on a pro-rata basis of one thirtieth of the monthly benefit for each day you are disabled. The benefit amount you select cannot exceed 60% of your regular monthly earnings or 40%, if you participate in California SDI.

Partial Disability Benefit Payments

Employees experiencing partial disability (as defined in the policy): are eligible to receive a benefit equal to 50% of their regular benefit amount for up to three months.

Proof of Loss

Disability income benefits are contingent on proof of loss. In most cases this requires medical information from your healthcare provider.

Benefit Duration

Benefits are paid directly to the employee covered under this insurance while the employee is disabled (as defined in the certificate), up to a maximum benefit duration of 3 months.

Portability

Coverage can be taken with you, up to age 70, if you are terminated by your current employer, have been covered under this plan for at least six consecutive months and are not disabled, on leave of absence, retired from this employer, or covered under any other group disability income plan.

When you leave your employer you must start work with another employer or your coverage will end 12 months from the date of portability. If you become employed by the end of the 12-month period, you can continue this disability income insurance. If your existing employer drops this group disability plan, you would no longer be eligible to continue this coverage.

Elimination Period

The elimination period is the number of days of total disability that the employee must wait before he or she can receive benefits. Your elimination period for this benefit is zero days if you are disabled due to injury and 14 days if you are disabled due to sickness.

Pre-Existing Conditions

Pre-existing conditions are defined as any injury or illness that you have been treated for within 12 months prior to the effective date of your coverage. Benefits will be paid for a pre-existing condition within the first 12 months after the policy became effective for the participant. However, the benefit payable will be 50% of the regular benefit amount and will be limited to six weeks. Any disability occurring after the first 12 months will be eligible for standard benefit payment amounts. Consult the certificate for a complete definition of pre-existing conditions.

Premium Waiver

All premiums are waived while an individual is receiving disability benefits payable under this policy, with the exception of the first premium.

Short Term Disability Insurance

ING Short Term Disability Insurance Rates

Rates listed are per \$100 of Benefit.

BENEFIT DURATION	ISSUE AGE	TWICE MONTHLY RATE/\$100
3 months.....	18-49.....	\$0.88
3 months.....	50-69.....	\$1.19
3 months.....	60-64.....	\$1.23

Rate Calculation Examples

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

Step 1: $\$64,800 \div 12 \text{ months} = \$5,400$ monthly income

Step 2: $\$5,400 \times 40\% = \$2,200$ maximum monthly benefit eligible to receive. (Round to the nearest \$100.)

Step 3: $\$2,200 \text{ benefit elected} \div \$100 = 22$

Step 4: $22 \times \$0.88 = \19.36 twice monthly premium

Cheryl is 50 years old and earns \$70,000 per year. She does not participate in SDI and is eligible for a 60% benefit maximum.

Step 1: $\$69,600 \div 12 \text{ months} = \$5,800$ maximum monthly income

Step 2: $\$5,800 \times 60\% = \$3,500$ maximum monthly benefit eligible to receive (raised to the nearest \$100)

Step 3: $\$3,500 \text{ benefit elected} \div 100 = 35$

Step 4: $35 \times \$1.19 = \41.65 twice monthly premium

To Estimate Your Cost

1. Determine your monthly income

\$ _____ Line 1

2. Determine your Monthly Benefit.

Do you participate in SDI? Yes/NO

If **yes** multiply your monthly income by 40%; the result is the maximum monthly benefit you are eligible to purchase.

If **no** multiply your monthly income by 60%; the result is the maximum monthly benefit you are eligible to purchase.

Select your benefit amount (you can purchase from \$300 up to your eligible maximum based on your salary or \$5,000 which ever is less.

\$ _____ Line 2

3. Divide the Benefit Amount you have selected in Line 2 by 100

\$ _____ Line 3

4. Multiply Line 3 by the appropriate rate and you will have your twice monthly premium.

\$ _____ Line 4

Important: Read Your Policy

These are plan highlights—not a contract. If these highlights and the policy differ, the policy will govern. Questions? Call EBS at (800) 229-7683.

Long Term Disability Insurance

a pre-tax flexible credit option, administered by UNUM

Long Term Disability (LTD) insurance can help safeguard your income if you experience a prolonged sickness or injury. This insurance coverage is available to employees only; dependents are not eligible. Also, because this is an employer offered benefit it is not portable if your employment with the City ends.

Employees who receive payment under this Long Term Disability Insurance plan are not eligible to receive payment under the City of San Francisco Catastrophic Illness Program.

Eligibility

- Individuals represented by the following collective bargaining units who qualify for membership in the Health Service System and are in active employment are eligible to apply for this LTD plan:
 - Municipal Executives Association (MEA) Units M, EM Code 351
 - Management Unrepresented Ordinance 158-98, Union Code 002
- Employees must be actively working at least 20 hours per week.
- Employees will be eligible on the first day of the benefit period following their first day of work.
- Unum will apply any prior period of work with your employer toward the waiting period to determine your eligibility date.
- If your employment ends and you are rehired within 12 months, your previous employment while in an eligible group will apply toward the waiting period. All other policy provisions apply.

Long Term Disability Payment Benefits

The maximum benefit is 66.667% of your monthly base earnings, up to no more than \$7,500 per month.

Disability payments will be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

Definition of Long Term Disability

You would be considered disabled and eligible for benefits if due to injury or sickness:

- You are limited from performing the material and substantial duties of your regular occupation, due to your sickness or injury; and have a 20% or more loss in your indexed monthly earnings due to the same injury or sickness.
- After benefits have been paid for 24 months, you are disabled when UNUM determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training and experience. Gainful occupation means an occupation that is or can be expected to provide you with an income at least equal to your gross disability payment.
- During the elimination period you are unable to perform any of the material and substantial duties of your regular occupation. The elimination period is the length of time of continuous disability which must be satisfied before you are eligible to receive benefits.
- The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Partial Disability

If you have met the definition of disability as stated above and have satisfied the elimination period, you can return to work on a part-time basis and still receive partial benefits, provided your earnings are at least 20% less per month than your pre-disability earnings due to that same injury or illness.

Important: Read Your Policy

These are plan highlights—not a contract. If these highlights and the policy differ, the policy will govern. Questions? Call EBS at (800) 229-7683.

Long Term Disability Insurance

Maximum Benefit Period

AGE AT DISABILITY	MAX PERIOD OF PAYMENT
Less than age 60	To age 60, but not less than 5 years
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

No premium payments are required for your coverage while you are receiving payments under this plan.

Disabilities That Are Not Covered

This plan does not cover disabilities caused by, contributed to by, or resulting from:

- Intentionally self inflicted injuries
- Active participation in a riot
- War, declared or undeclared, or any act of war
- Conviction of a crime under state or federal law
- Loss of professional license, occupational license or certification.
- UNUM will not pay a benefit for any period of disability during which you are incarcerated

Mental and Nervous

Disabilities due to a sickness or injury which are primarily based on a self reported symptoms and disabilities due to mental illness have a limited payment period of 24 months per lifetime. Mental and nervous benefits would continue beyond 24 months only if you are institutionalized or hospitalized as a result of the disability.

How Much Will the Plan Pay If You Are Disabled?

- Multiply your base monthly earnings by 66.667%
- The maximum monthly benefit is \$7,500
- Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your gross disability payment.
- Subtract from your gross disability payment any deductible sources of income.

The amount calculated above is your monthly payment.

How to Calculate Premiums

To calculate your premium for this coverage complete the calculation below. Note: If your monthly salary exceeds \$11,250 use \$11,250 as your Current Monthly Salary in the calculation.

Your Monthly Salary : \$ _____ x .0051 =
 \$ _____ Estimated Monthly Cost

Example A:

Employee annual salary \$30,000 (\$2,500/month)

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

Example B:

Employee annual salary \$150,000 (\$12,500/month)

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

The effective date of your coverage will be delayed if you are not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would become effective.

Accident Insurance

a pre-tax flexible credit option administered by Allstate

Why Accident Insurance?

Accident insurance can help offset the loss of income resulting from a covered accidental injury. This type of coverage does not pay medical providers – it pays benefits directly to you. So it is not a substitute for primary or secondary medical coverage.

Policy Features

- Guaranteed renewable until age 70, subject to change in premiums by class
- Choose from individual or family coverage
- Benefits are paid directly to the insured, unless otherwise assigned
- Benefits are in addition to any other insurance the insured may have

The plan pays benefits for covered on or off the job accidental injuries, which result within 90 days (180 days for loss of life or limb) of the covered accident. Losses must be diagnosed by a physician. There are three levels of coverage available. Your policy will pay benefits based on the level of coverage you purchase.

Accident Policy Benefits

Accidental Death and Dismemberment

Up to \$60,000 maximum for primary insured; up to \$30,000 maximum for spouse if covered; and up to \$5,000 maximum per child if covered. If accident occurs while covered person is a fare paying passenger on a common carrier, policy pays up to 3 times the maximum amount.

Dislocation or Fracture

Up to \$2,000 maximum for primary insured; up to \$1,000 maximum for spouse if covered; and up to \$500 maximum for each child if covered. Amount paid depends on dislocation or fracture as shown in the policy schedule. Only dislocations or fractures listed in the policy schedule are covered.

Hospital Confinement

Choice of \$100/\$200/\$300 per day. AWD pays the amount elected for each day a covered person is admitted to and confined as an inpatient in a hospital up to a maximum of 90 days for each period of continuous hospital confinement. Hospital must be located in the United States or its territories.

Ambulance

(if needed as a result of accidental injury)
\$100/\$200/\$300 AWD pays the amount elected for transfer to or from a hospital by regular ambulance.
\$200/\$400/\$600 AWD pays the amount elected for transfer to or from a hospital by air ambulance.

Disability

Choice of \$600/\$1200/\$1800 per month, payable to the primary insured only, beginning the first day if totally disabled as a result of an injury for 3 full days. Payable for only one disability at a time. Maximum benefit period 6 months. For any period of disability less than one full month, 1/30th of the monthly disability is paid for each day of total disability.

Important: Read Your Policy

These are plan highlights—not a contract.
If these highlights and the policy differ,
the policy will govern. Questions?
Call EBS at (800) 229-7683.

Accident Insurance

Medical Expenses

Medical expenses up to \$250/\$500/\$750. Includes physician fees, X-rays, emergency services and repair to sound natural teeth if diagnosed by a dentist to have resulted from the accident. Emergency room services are included in the maximum amount and are limited to a maximum of \$50. Treatment must be received in the United States or its territories.

Sickness Disability Income Rider

Benefits are provided if the insured is totally disabled as a result of sickness not resulting from injury. After the 7 day elimination period (which is not retroactive) AWD pays the amount elected each month up to a maximum of 6 months when the insured employee is totally disabled as described below.

Total disability resulting from pregnancy or childbirth is covered the same as any covered sickness if the rider has been in effect for the 10 consecutive months preceding the commencement of such total disability. Total disability resulting from complications of pregnancy or childbirth are treated the same as any other sickness.

The insured employee is totally disabled when, due solely to sickness, he or she is unable to perform with reasonable continuity the substantial and material acts necessary to pursue his or her usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which he or she could reasonably be expected to perform satisfactorily in light of his or her age, education, training, experience, station in life, physical and mental capacity.

Outpatient Physician's Treatment Benefit Rider

AWD pays a benefit when a covered person is treated by a physician outside of a hospital. This benefit is limited to 2 visits per calendar year, per covered person, and a maximum of 4 visits per calendar year if the policy is in force as family coverage. Treatment can be for sickness, annual wellness exams, or other visits to a physician outside of a hospital.

ACCIDENT INSURANCE PREMIUMS TWICE MONTHLY		
BASIC COVERAGE	Accident Only	Accident/Sickness
Individual	\$10.79	\$14.65
Family	\$18.70	\$22.53
ENHANCED COVERAGE	Accident Only	Accident/Sickness
Individual	\$20.52	\$28.23
Family	\$36.31	\$44.03
PREMIER COVERAGE	Accident Only	Accident/Sickness
Individual	\$30.25	\$41.80
Family	\$53.95	\$65.50

Accident Insurance

Accident Insurance Policy Termination and Grace Period

The policy terminates at the earliest of the end of the grace period, the end of the policy year in which the insured becomes age 70, or the insured's death. The spouse, if covered under the policy, becomes the new insured upon the insured's death. A grace period of 31 days is granted for payment of a premium falling due after the first premium is paid. The policy remains in force during the grace period. If you spouse is a covered person, the spouse's coverage ends upon valid decree of divorce. If your child is a covered person, the child's coverage ends on the policy anniversary next following the date the child is no longer eligible, which is either when the child marries or reaches age 21 (25 if a full-time student at a regular educational institution of higher learning beyond high school). Benefits shown are provided by 1 unit of Accidental Death and Dismemberment Policy AP2 or state variations thereof. This is an Accident Only policy which does not pay for any loss from sickness. Coverage is for on or off the job accidents. Provides supplemental medical expense coverage. A Sickness disability Income rider and/ or Sickness Hospital Confinement Rider can be added to this policy. (Contact your agent for more details.) This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy itself sets forth, in detail, the rights and obligations of both the insured and the insurance company.

Pre-Existing Condition Limitation

The sickness disability Income and Sickness Hospital Confinement riders have pre-existing condition limitations. A pre-existing condition is a condition which manifested itself within 2 years prior to the effective date of coverage; or for which medical advice or treatment was recommended by or received from a physician in the 2 year period prior to the effective date of coverage. If the insured has a pre-existing condition as defined, we will not pay benefits for such condition as defined, we will not pay benefits for such condition during the 2 year period beginning on the rider date, unless the condition was disclosed without material misrepresentation in answer to questions in the application for the rider, and is not excluded by name or specific description.

Exclusions and Other Limitations

The Sickness Hospital Confinement and sickness disability Income riders do not pay benefits due to sickness caused by or resulting from: any act of war, whether or not declared, participation in a riot, insurrection or rebellion; or attempted suicide, while sane or insane; or being under the influence of alcohol, narcotics or any other controlled substance or drug unless administered upon the advice of a physician; or alcoholism, drug addiction or dependence upon any controlled substance; or voluntary inhalation of gas or fumes; or mental illness without demonstrable organic disease. In addition, the Sickness Hospital Confinement Rider will not pay benefits for conditions caused by or resulting from: dental or plastic surgery for cosmetic purposes, unless the surgery is required to correct a disorder of normal body functions; a newborn child's routine nursing or routine well baby care; or childbirth unless this rider has been in effect for the 10 consecutive months preceding the hospital confinement (complications of pregnancy or childbirth are covered to the same extent as a sickness).

Policy AP2 or state variations thereof, does not cover any loss incurred as a result of injury incurred prior to the effective date of coverage, subject to the Incontestability Provision; or any act of war whether or not declared, participation in riot, insurrection or rebellion; or suicide or any attempt at suicide, whether sane or insane; or intoxicants or controlled substances; we are not liable for loss sustained or contracted in consequence of any person being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician; or any bacterial infection (except pyogenic infections which shall occur with and through an accidental cut or wound); or participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or the taking of poison or asphyxiation from or voluntary inhaling of gas or fumes; or committing or attempting to commit an assault or felony; or driving in any organized race or speed test or while testing an automobile or any vehicle on any racetrack or speedway; or mental diseases or deficiencies without demonstrable organic disease; or injuries sustained by a dependent child while practicing for or participating in an organized competitive football game; or hernia, including complications due to hernia. Any injury sustained while a covered person is an active member of the Military, Naval or Air Forces of any country or combination of countries is not covered. Upon notice and proof of service in such forces, we will return the prorated portion of the premium paid for any period of such service*. Disability benefits due as a result of sprained, strained or lame back or any intervertebral disc conditions are limited to 3 months for any one injury.

Cancer Insurance

a pre-tax flexible credit option, administered by Allstate

Cancer and specified disease insurance can help you manage the high expenses of treatment; preserve savings; protect your family from financial hardship; concentrate on getting well. Similar to life insurance, this insurance pays cash benefits directly to the insured, helping to offset the loss of income that can result if you suffer from a covered illness. This type of coverage does not pay medical providers, so it is not a substitute for primary or secondary medical coverage.

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

This insurance also pays benefits for Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Typhoid Fever, Bubonic Plague, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Epidemic Cerebrospinal Meningitis, Undulant Fever, Sickle Cell Anemia, Rocky Mountain Spotted Fever, Smallpox, Addison's Disease, Hansen's Disease and Tularemia.

If these highlights and the policy differ, the policy will govern. Questions? Call EBS at (800) 229-7683.

Wellness Benefit Rider

Pays \$75 or \$100 each year for each covered person for specified cancer screening tests: Bone Marrow Testing; CA15-3 (test for breast cancer; CA125 (test for ovarian cancer); CEA (blood test for colon cancer); chest X-ray; colonoscopy; flexible sigmoidoscopy; hemocult stool analysis; PSA (test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); or biopsy for skin cancer. This benefit is payable annually for each covered person regardless of the outcome.

Cancer Initial Diagnosis Level Benefit Rider

Pays \$2,000, \$4,000, or \$5,000, (depending on what you choose.) a one-time benefit of the amount shown, when a person is diagnosed, (other than skin cancer).

Benefits

Hospital Confinement

The Policy has benefit options of \$200/\$300/\$400 day of continuous hospital confinement up to 70 days.

After the 70th day, we pay \$30 for each day thereafter of continuous hospital confinement.

At Home Nursing

Pays charges up to \$100 each day for private nursing care and attendance by a nurse at home. Must be required and authorized by the attending physician. Limited to the number of days of the previous continuous hospital confinement.

Government Hospital

AWD pays \$100 each day in lieu of all other benefits in the policy when confined to a hospital operated by or for the U.S. Government, (including the Veteran's Administration). In the event the hospital does not impose a charge for treatment, benefits will be as provided in any other hospital.

Surgery (Per Schedule in Policy)

Actual charges up to \$3,000 maximum depending on surgery. Outpatient surgery is paid at 150% of the surgical benefits, up to \$4,500.

Second Surgical Opinion

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

Anesthesia

Actual charges of an anesthetist up to the greater of 25% of the amount paid for surgery or \$100.

Ambulatory Surgical Center

AWD pays charges up to the amount shown each day when surgery is performed at an Ambulatory Surgical Center.

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

Actual charges up to \$10,000/\$15,000/\$20,000 each 12 month period beginning with the first day of benefit under this provision for covered treatment techniques used for the modification or destruction of cancerous tissue. CER1 Increases the benefit by \$5000 per unit each 12 month period beginning with the first day of benefit under the policy provision. CER1 Pays only after the \$10,000 each 12 month limit in CP10B is reached. The 12 month period in CER1 Runs concurrently with the 12 month period in CP10B and CER1 combined pay up to the maximum shown each 12 month period.

Cancer Insurance

New or Experimental Treatment

Actual charges up to \$10,000 every 12-month period.

Inpatient Drugs and Medicine

Actual charges up to \$250 maximum.

Blood, Plasma and Platelets

Actual charges up to \$10,000/\$15,000/\$20,000 each 12 month period beginning with the first day of benefit under this provision for blood, plasma, platelets and transfusions (including administration charges); processing and procurement costs; and cross matching. CER1 pays only after the \$10,000 each 12 month limit in CP10B is reached. The 12 month period in CER1 runs concurrently with the 12 month period in CP10B, CP10B, & CER1 combined pay up to the maximum shown each 12 month period. Donor replaced blood is not covered.

Physician's Attendance

Actual charges up to the \$30 per day for up to 70 days for a visit by a physician during a covered hospital confinement. Limited to one visit a day by one physician.

Private Duty Nursing Services

Actual charges up to the amount elected each day for up to 70 days while hospital confined when required and authorized by the attending physician.

Skin Cancer

Actual charges for removal of skin cancer up to \$120 for 1st removal, when a physician who is not a pathologist diagnoses it. If more than one skin cancer is removed at the same time, the policy pays \$60 for each additional skin cancer removed. Skin cancers diagnosed by a pathologist are eligible for other policy benefits.

Prosthesis

Actual charges up to \$2,000 for each prosthetic device prescribed as a direct result of surgery for cancer or specified disease treatment and which requires surgical implantation. Limited to \$2,000 for each covered person, for each amputation.

Ambulance

Actual charges up to \$200 on continuous hospital confinement for transportation by a licensed ambulance service, for transporting a covered person.

Non-Local Transportation

AWD pays the cost of round trip coach fare by common carrier or \$0.40 for each mile up to 700 miles for round trip personal vehicle transportation for treatment at a hospital (inpatient or outpatient).

Outpatient Lodging

Actual charges up to \$100 per day; maximum \$4,000 for a 12 month period.

Family Member Lodging and Transportation

- Lodging: Actual charges up to \$100 per day for hotel accommodations (60 days for each continuous confinement).
- Transportation: 1) Actual cost of round trip coach fare on common carrier; or 2) \$0.40 per mile up to 700 miles round trip (70 mile minimum round trip).

We do not pay the Family member Transportation benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation benefit, when the family member lives in the same city or town as the covered person.

Physical or Speech Therapy

Actual charges up to \$25 per day

Extended Care Facility

Actual charges up to \$100 per day (limited to the number of days of previous hospital confinement and must begin within 14 days after hospital confinement).

Mammography Benefit

Greater of \$50 or whatever the charges are, up to \$200) for baseline mammography for women ages 35-39; inclusive; mammography every 2 years, or more frequently upon a physician's recommendation for women 40 - 49; and annual mammography for women ages 50 and over.

Cervical Cancer Screening Test

Greater of \$50 or charges up to \$200 for annual cervical cancer screening test.

Waiver of Premium

Pays premiums after insured is disabled for 90 days. Disability must be a direct result of cancer diagnosed after the first 30-days of coverage.

Cancer Insurance

Cancer Initial Diagnosis Level Benefit Rider

Pays a one-time benefit for each covered person, when a covered person is diagnosed for the first time ever as having cancer (other than skin cancer). The first diagnosis must occur after the waiting period and is payable only once for each covered person.

Optional Benefits

Hospital Intensive Care Rider

This rider is not disease specific and pays a benefit for covered confinement for any covered illness or accident from the very first day of confinement, in intensive care. Coverage begins with the first day of admission and pays up to 45 days. For time periods less than a day (24 hours), a pro-rata share of the daily benefit is paid. Daily benefit amount is \$600 per day.

Eligibility/Termination

Coverage may include you, your spouse and dependent children as defined in the policy. Coverage for dependent children terminates on the policy anniversary next following the date the child is no longer eligible, which is either when the child marries or reaches age 21 (25 if a full-time student at an educational institution of higher learning beyond high school). Coverage for the insured's spouse ends upon valid decree of divorce.

Renewability

The policy is guaranteed renewable for life, subject to change in premiums by class. All premiums may change on a class basis. A notice is mailed in advance of any change.

If these highlights and the policy differ, the policy will govern. Questions? Call EBS at (800) 229-7683.

PREMIUMS FOR ALLSTATE CANCER INSURANCE		
BASIC COVERAGE	Base Plan	Base Plan + ICR2
Individual	\$11.05	\$14.06
Family	\$18.57	\$24.57
ENHANCED COVERAGE	Base Plan	Base Plan + ICR2
Individual	\$14.08	\$17.07
Family	\$24.05	\$30.05
PREMIER COVERAGE	Base Plan	Base Plan + ICR2
Individual	\$18.22	\$21.23
Family	\$31.63	\$37.61

Issue Ages: 18-64/Rates are Twice Monthly

Waiting Period, Exceptions & Limitations

The policy and riders contain a 30-day waiting period that begins on the effective date. No benefits are payable for any covered person who has cancer or a specified disease diagnosed before coverage has been in force 30 days from the effective date, except should a covered person have cancer or a specified disease first diagnosed after signing the application and before the end of the waiting period, benefits for treatment of that cancer or specified disease will apply only to loss commencing after 2 years from the effective date of the policy; or at your option, you may elect to void the policy from the beginning and receive a full refund of premium, in accordance with the Notice of 30 Day right to Examine Policy Provision. The policy does not pay for any loss except for losses due directly from cancer specified disease. Diagnosis must be submitted to support each claim. The policy does not pay for any disease or incapacity that has been caused, complicated, worsened or affected by cancer or a specified disease or as a result of cancer or specified disease treatment. Treatment must be received in the United States or its territories.

This booklet highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy itself sets forth, in detail, the rights and obligations of both the insured and the insurance company. This is a Limited Benefit Cancer and specified Disease Policy with Optional Riders. The policy and riders are not a Medicare Supplement Policy. Allstate Financial Workplace Division is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a wholly owned subsidiary of the Allstate Corporation. ©2002 American Heritage Life Insurance Company allstate.com.

Heart & Stroke Insurance

a pre-tax flexible credit option, administered by Allstate

Help protect yourself and your family against the financial hardship that can result from heart disease. Similar to life insurance, this insurance pays cash benefits directly to the insured, helping to offset the loss of income that can result if you suffer from a covered illness. This type of coverage does not pay medical providers, so it is not a substitute for primary or secondary medical coverage.

Policy Features

This benefit pays cash directly to the insured (unless otherwise assigned) for the service and treatment administered to or received by a covered person for a heart attack, heart disease or stroke. Such treatment or service must be a) incurred by a covered person while coverage under the policy is in force on that person; b) necessary for the care and treatment of a heart attack, heart disease or stroke. The Heart & Stroke Insurance plan provides benefits for the following types of services:

- Hospital Confinement
- Physiotherapy
- Oxygen
- Blood, Plasma and Platelets
- Coronary Angioplasty
- Coronary Artery Bypass Graft Operation
- Heart Transplant
- Surgery and Anesthesia
- Non-Local Transportation
- Inpatient Drugs and Medicine
- Physician's Attendance
- Private Duty Nursing
- Cerebral or Carotid Angiogram
- Cardiac Catheterization
- Pacemaker Insertion
- Thromboendarterectomy
- Second Surgical Opinion
- Cardiograms
- Ambulance
- Family Member Lodging and Transportation

Hospital Intensive Care Rider

This optional rider pays a benefit for covered confinement in a hospital intensive care unit for any covered illness or accident from the very first day of confinement. Benefits are paid in addition to other insurance coverage.

Exclusions & Limitations

Exclusions and limitations to the policy also apply to the rider. This highlights some features of the policy, but is not the insurance contract. Only the actual policy provisions control the benefits. The policy itself sets forth, in detail, the rights and obligations of both the insured and the insurance company. Please read the actual policy before deciding if this option is right for you and your family.

Renewability

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

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

Termination of Insurance

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

Heart & Stroke Insurance

Exclusions and Limitations

This policy provides benefits only for Heart Attack, Heart Disease or Stroke. This policy does not cover any other disease or sickness or incapacity other than Heart Attack, Heart Disease or Stroke even though such disease, sickness or incapacity may be caused, complicated or otherwise affected by Heart Attack, Heart Disease or Stroke. If a covered confinement is due to more than one covered condition, benefits will be payable as though the confinement were due to one condition. If a confinement due to a covered disease is also due to a condition that is not covered, benefits will be payable only for the part of confinement attributable to the covered condition.

Pre-Existing Condition Limitation

A pre-existing condition is not revealed in the application for which: symptoms existed within a 6 month period before the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis care or treatment; or medical advice

or treatment was recommended by or received from a physician within the 6 month period before the effective date of coverage. If a covered person has a pre-existing condition, the plan does not pay benefits for such conditions under this policy or any riders attached to this policy during the 6 month period beginning on the date that person became a covered person. If the loss is not due to a pre-existing condition, then the pre-existing condition limitation does not apply.

Important: Exclusions and limitations to the policy also apply to the rider. This highlights some features of the policy, but is not the insurance contract. Only the actual policy provisions control. The policy itself sets forth, in detail, the rights and obligations of both the insured and the insurance company.

If these highlights and the policy differ, the policy will govern. Questions? Call EBS at (800) 229-7683.

PREMIUMS FOR ALLSTATE HEART & STROKE INSURANCE	
BASIC COVERAGE	
Individual	\$8.99
Family	\$17.33
ENHANCED COVERAGE	
Adding Cancer Initial Diagnosis Rider \$10,000	
Individual	\$15.80
Family	\$30.92
PREMIER COVERAGE	
Adding Cancer Initial Diagnosis Rider \$10,000 plus Hospital Intensive Care Rider \$200/day	
Individual	\$18.88
Family	\$33.13

Issue Ages: 18-64

Rates are Twice Monthly

Long Term Care Insurance

a post-tax flexible credit option, administered by MetLife

On average, Americans will spend more years caring for parents than they will raising children. A long-term care insurance policy can help protect your assets from the rising cost of custodial care.

- 48.6% of people age 65 and older may spend time in a nursing home.
- 71.8% of people over the age of 65 may use some form of home healthcare.
- The US annual average nursing home cost is \$69,700 – based on semi-private room, 7 day a week care.

Medical insurance and Medicare pay for hospital, physician, surgical, rehabilitation, outpatient, and treatment expenses. These types of coverage do not pay for routine long term care and assistance when chronic illness or disability prevents an individual from tending to his or herself. (Medicaid may pay for long-term custodial care if an individual meets required asset and income eligibility requirements.)

Policy Highlights

- Portability: coverage may be continued even if the member is no longer affiliated with the employer; the member retains the 10% Premium Discount.
- Renewability: policy cannot be cancelled as long as premiums are paid on time.
- Premiums can only be raised as the result of a rate increase made on a class-wide basis in California and approved by the Department of Insurance.
- A 30% discount will be applied when both you and your Spouse or Domestic Partner are accepted for coverage.
- A 15% “Marital discount” is applied if you apply for coverage, as a couple, and only one is accepted for coverage.

Your long term care policy describes the types of coverage provided as well as exclusions, limitations, reductions in benefits, what you must do to keep your policy in force and what would cause your policy to be discontinued. If these highlights and the policy differ, the policy will govern. Questions? Call EBS at (800) 229-7683.

Eligibility

Employees who are actively at work, as well as spouses, parents, parents-in-law, stepparents, step-parents-in-law, children and stepchildren (ages 18-84) are eligible for coverage.

MetLife Ideal Partnership Long Term Care

Nursing Home Daily Benefit.....	100%
Residential Care Facility Benefit.....	100%
100%Home Healthcare Benefit.....	100%
Elimination Period	90 days
Benefit Period	3 years
Daily Benefit	\$150.00
Payment Type.....	Life-Pay
Underwriting Class.....	Standard

Sample: Partnership Long Term Care Insurance Rates

Age	Twice Monthly Cost
18-30	\$51.46
35.....	\$58.19
40.....	\$63.56
45.....	\$69.41
50.....	\$74.96
55.....	\$80.94
60.....	\$100.80
65.....	\$135.92
69.....	\$187.14
70.....	\$204.67
75.....	\$329.28

Note: Rates do not increase as you move into the next age bands. (The rates listed above are subject to change and should be used as samples only. They illustrate a 10% discount for a Multi-Life group rate. Many factors determine the rates. Smoking, health, whether Spouse or Domestic Partner is applying, what riders you choose, etc. Your EBS counselor will use a calculator to finish. The rates may change further, after it goes through underwriting process. Note: If a spouse/domestic partner enrolls with EE, a discount of 30% will be applied to the final rates. This illustration is a general description of coverage and is not a contract. For a rate quote you must speak with your EBS enrollment counselor. Any differences in premiums between this illustration and those quoted will be determined in favor of the quoted rates. Please review your policy for all terms and conditions.

Pet Care Insurance

a post-tax flexible credit option; administered by PetCare

QuickCare Gold

The most comprehensive coverage. Accident and illness coverage that protects your cat or dog in virtually any situation. Choose between 70% or 90% coverage.

- Accident – Cat \$2,500/Dog \$3,000 – Coverage amount is for each separate accident.
- Illness – Cat \$2,500/Dog \$3,000 – Total lifetime coverage per illness category; cardiovascular & respiratory system; Digestive system; Urogenital system-Musculoskeletal system; Nervous system. Eyes-ears-skin-endocrine system; Blood & lymphoid system-infectious diseases-cancer.
- Accidental Death - \$500 (No deductible) – If your pet should die from injuries as a result of an accident, its original purchase price will be reimbursed, up to policy limits.
- Boarding Kennel Fees - \$250 (No Deductible) Boarding or home care for your pet to a maximum of \$25/day should you become hospitalized for more than 48 hours and are unable to provide pet care.
- Recovery Costs - \$150 (No deductible) – To pay for advertising or to offer a reward should your pet become lost or missing.

Deductible \$100 for Accident or Illness

QuickCare Gold Advantages

- Unlimited number of accidents covered
- No maximum annual illness benefit restrictions
- Eligible enrollment age 8 weeks–10 years (cat), 8 years (dog), 6 years (select breed dog).
- Lifetime coverage once enrolled in the program
- Lifetime maximum illness coverage \$30,000 (cat), \$36,000 (dog), split equally into 12 illness categories

QuickCare Gold Twice Monthly Premiums

Plan	Cat	Dog
70% Coverage.....	\$ 9.98	\$14.03
90% Coverage.....	\$12.68.....	\$23.03

For QuickCare Gold, medical records will be requested at the time of enrollment.

Some breeds are more susceptible to certain illnesses; therefore premiums are slightly higher for the following “select” breeds: Basenji, Basset Hounds, Boxers, Bulldogs, Bull Terriers, Dalmations, Deerhounds, Doberman Pinschers, Dogue de Bordeaux, German Shepherds, all Greyhounds, Great Danes, Irish Wolfhounds, Leonbergers, all Mastiff breeds, all Mountain Dogs, Newfoundlands, Old English Sheepdogs, Rottweilers, St Bernards and Wheaten Terriers. All Shar-Pei’s and Shar-Pei crossbreeds are excluded from illness coverage and eligible for accident coverage only.

QuickCare

Selected Accident Only coverage for cats and dogs.

Coverage Amounts and Description

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

- Foreign Body Ingestion: \$2000 / An ingested foreign body needs to be surgically removed.
- Motor Vehicle Accident: \$2000 / Medical treatment for injuries resulting from any form of motor vehicle accident.
- Bone Fractures: \$2000 / Fractures not caused by a motor vehicle accident.
- Poison Ingestion: \$1500
- Lacerations: \$500 / Medical treatment for an accidental laceration such as cut pads or dog/cat bites and abscesses.
- Burns: \$500
- Allergic Reaction to Insect Bites/Stings: \$500
- Accidental Death: \$500 (No deductible) / If your pet should die from injuries as a result of an accident, its original purchase price will be reimbursed, up to policy limits.

Deductible \$50 (unless otherwise noted)

QuickCare Twice Monthly Premiums

Cat.....	\$5.48
Dog.....	\$5.93

Pet Care Insurance

Quickcare Optimum

Illness Coverage: First time Illness diagnosis.

Accident Coverage: Foreign Body; Motor Vehicle Accident; Poison Ingestion; Bone Fracture; Lacerations; Burns; Allergic Reaction to Insect Bites.

Wellness Plan: up to \$150 annually for vaccinations, annual physical exam, spay/neuter, heartworm, teeth cleaning.

Additional Benefits: Recovery Costs of advertising a reward should your pet be lost or stolen. Euthanasia and Cremation, to cover the cost for euthanasia, burial, and cremation.

Deductible \$100 for Accident or Illness

QuickCare Optimum Twice Monthly Premiums

Cat..... \$13.56

Dog..... \$15.81

Quickcare for Indoor Cats

Selected accident and illness coverage for kittens and cats that live primarily indoors.

- Feline Lower Urinary Tract Disease (FLUTD): \$2,500 (\$200 deductible)
- Cancer: \$2,500 (\$200 deductible) / Should your cat be diagnosed with any malignant tumor, diagnosed by histopathology
- Infectious Disease: \$2,500 (\$200 deductible)
- Feline Asthma: \$2,500 (\$200 deductible)
- Diabetes Mellitus: \$2,500 (\$200 deductible)
- Foreign Body Ingestion: \$2,000 / An ingested foreign body needs to be surgically removed
- Bone Fractures: \$2,000
- Poison Ingestion: \$1,000
- Feline High-Rise Syndrome: \$1,500 / Medical treatment for injuries resulting from accidentally falling from an elevated dwelling
- Bite Wounds and Bite Wound Abscesses: \$500
- Burns: \$500

Deductible \$50 (unless otherwise noted)

QuickCare for Indoor Cats Advantages

- Unlimited number of (listed) accidents covered
- No 30 day waiting period
- No age limitations for enrollment
- Enrollment as early as 8 weeks of age

QuickCare Twice Monthly Premiums for Indoor Cats

Cat..... \$6.38

Quickcare Senior

Selected accident and illness coverage with no age limitations specially tailored for senior cats and dogs.

Coverage Description

Includes, but is not limited to: prescribed medication, X-rays, surgeries, hospitalization, ultrasounds, MRI/CAT scans, homeopathic treatments including acupuncture and chiropractic, chemotherapy and referrals.

Deductible \$50 (unless otherwise noted)

QuickCare Senior Advantages

- Pick Your Veterinarian. You can use any licensed veterinarian of your choice.
- Hereditary and Chronic Defects Coverage. Provides coverage for hereditary and chronic defects, including hip dysplasia.
- No Itemized Restrictive Schedule of Benefits
- Benefit from PetCare's Maximum Discount

QuickCare Senior Twice Monthly Premiums

Cat..... \$10.88

Dog..... \$15.83

Enrolling Your Pet

You will need to bring the following information with you to enroll your pet: veterinarian provider's name, address and phone number, as well as the date of the pet's most recent physical exam and vaccination history. Your pet's medical records will be requested on the application. Enrolled pets must have an annual physical exam each year, to keep the policy in force. Policy renews annually. Questions about your policy? Contact PetCare at (866) 275-7387.

Pre-Paid Legal

More Americans are realizing that legal problems are a fact of life and that legal protection is a necessity. As a Pre-Paid Legal member, legal assistance is just a phone call away. Eligible employees, spouses and dependent children up to age 21 are covered under this plan. (Dependents who are full time students are covered to age 23. Proof is required; see your membership packet for details.)

You'll have your Provider Attorney's toll-free consultation number on the back of your membership card. When you call your Provider Attorney's office and give the nature of your legal question or problem, you will be asked for a time when it would be convenient for an attorney to call you.

Preventative Legal Services

Unlimited Phone Consultations

You have unlimited toll-free access to your Provider Attorney for personal or business related legal matters immediately after you enroll. You can call your Provider Attorney's toll-free number during regular business hours.

Phone Calls and Letters

A phone call or letter from your Provider Attorney can get you the results you want fast. Your Provider Attorney will recommend a letter or phone call when that is the best legal step for you. One call or letter per personal subject related matter is free with membership. Plus you're entitled to two business letters each year at no additional cost. Additional assistance on the same subject is provided at a 25% discount.

Contract and Document Review

You can have an unlimited number of personal legal documents of up to 10 pages each reviewed by your Provider Attorney. Included each year is one business document review at no additional cost. Your Provider Attorney will analyze the documents and suggest any beneficial changes before you sign.

Wills for You and Your Family

Included in this program is a will for you at no additional charge. Not just a "simple" will, but one that meets most American's needs with free yearly reviews and updates. Wills for covered family members are just \$20 each; changes and updates are \$20. Trust preparation is available at 25% discount.

Motor Vehicle Legal Services

Minor Legal Expenses

Your Provider Attorney will represent you or your eligible covered family members against moving traffic violations at no additional cost to you. Now you can have help with traffic tickets and not have to worry about the cost of representation.

Major Legal Expenses

Your Provider Attorney will defend you or your covered family members when you are charged with Manslaughter, Involuntary Manslaughter, Negligent Homicide, or Vehicular Homicide at no added cost to you.

Important: Read Your Contract

These are plan highlights—not a contract. If these highlights and your contract differ, the contract will govern. Questions? Call Pre-Paid Legal at (800) 654-7757.

Pre-Paid Legal

Trial Defense Services

During your first year of membership, you have up to 60 hours of your Provider Attorney's time at no additional cost when you or your spouse is named defendant or respondent in a covered civil or criminal action filed in court. The criminal action must arise out of the performance of the covered person's employment responsibilities. Your Provider Attorney can advise you on the documents required to determine coverage under this benefit.

Of these 60 hours, up to 2.5 hours may be used for all legal services rendered in defense of a covered suit prior to actual trial. Up to 57.5 of the remaining hours are available for actual trial time, including covered preliminary hearings.

Your available hours of service increase when you renew your membership as follows:

- 2nd year renewal - 3 hours of pre-trial time plus 117 hours of trial time at no added cost
- 3rd year renewal - 3.5 hours of pre-trial time plus 176.5 hours of trial time at no added cost
- 4th years renewal - 4 hours of pre-trial time plus 236 hours of trial time at no added cost
- 5th year renewal - 4.5 hours of pre-trial time plan 295.5 hours of trial time at no added cost.

IRS Audit Legal Services

Your Pre-Paid Legal membership will help you defray the costs of an IRS audit and give you the legal support you need.

You have up to 50 hours of your Provide Attorney's time available at no additional cost when you or a covered family member receives a written notice of an IRS audit or is requested to appear at IRS offices regarding your tax return. Your 50 hours are available as follows:

- Up to one hour for consultation, advice, and assistance when you receive written notice from the IRS of an audit or appearance.

- If there is no settlement within 30 days, you have up to 2.5 hours for audit representation, negotiations, phone conversations, and settlement conferences prior to litigation.
- If there is no settlement without litigation, up to 46.5 hours are available for actual trial appearance if the IRS sues you or if you pay the disputed tax and sue the IRS.

Should you need legal services not covered by this plan, your Provider Attorney will render assistance at a 25% reductions to his or her standard hourly rate for you or any covered dependent. (Hourly rates for referral attorneys and court appearances may vary.) Please note that a retainer may be required for services to be rendered under this benefit. Your Provider Attorney must have five days notice prior to court representation. Telephone advice is available immediately.

Pre-Paid Legal Twice Monthly Premiums

Family Plan.....	\$7.48
Family Plan w/Legal Shield Benefit Option	\$7.98

This benefit is portable without rate increase. The plan covers member, member's spouse or domestic partner, never married dependent children up to the age of 21 living at home, never married dependent children who are full time students up to the age of 23.

Corporate and Business Tax Returns Not Covered Under This Plan

Coverage for IRS related services begins with the tax return due April 15 of the year you enrolled.

Miscellaneous Reimbursements

Members may allocate flexible credits towards the post-tax Miscellaneous Reimbursement Account. In order to be reimbursed from this account, members are required to submit a claim directly to EBS. For most qualifying expenses proof of the expense, such as a receipt, is required.

Qualifying Expenses

MEA Dues

MEA members must sign up for a payroll deduction to pay their Association dues in order to have those dues reimbursed. You can also use this account for other professional association dues and auto club dues.

Health Club and Fitness

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 may be reimbursed. (Prescription smoking cessation programs are eligible for pre-tax reimbursement through the healthcare contribution reimbursement option).

Auto and Homeowners Insurance

Auto, homeowners and renters insurance expenses are eligible. In order to be reimbursed you must submit a receipt showing premium payment.

Executive Coaching

Executive coaching gives one-on-one support and motivation for your personal and professional life. Reimbursement requires submitting receipts from an eligible coaching professional.

State Disability Insurance

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

Prior Service Buy Back

If you are having a deduction from paycheck to purchase "prior service" you can be reimbursed for this deduction. Submit a copy of your pay stub with your claim. If you make cash payments to a Retirement System, submit the receipt for reimbursement.

Tuition

If you are participating in any training program and you have exceeded your \$1000 allocation from the MEA training fund, you may be reimbursed the excess through this plan. Only classes that are qualified under the training program through the MEA training fund are eligible. Submit a receipt with your claim indicating the excess over \$1000 for qualified classes.

San Francisco Cultural and Entertainment Events

Events that are partially or fully sponsored by the Hotel Tax Fund or operated directly by the City and County of San Francisco are eligible. For example, entry to or membership in the San Francisco Zoo, Academy of Science, Opera, Asian Art Museum, deYoung Art Museum, San Francisco Symphony, the San Francisco Ballet and similar organizations qualify for reimbursement. This includes membership, season tickets, individual tickets, or other contributions. Submit receipts with your claim for reimbursement.

Long Term Care Insurance

If you are purchasing long term care through PERS you may use the Miscellaneous Reimbursement Account for some or all of that premium cost. Employees must enroll through PERS directly for the benefit to be reimbursed. Note: see page XX of this guide for information about the post-tax Long Term Care insurance option that can be purchased with flexible credits via payroll deduction.

Pre-Tax Retirement System Deductions

If you are having a pre-tax retirement deduction for your employer's retirement system taken from your paycheck, you can be reimbursed through this account. Submit a copy of your paycheck stub showing the deductions with your claim. Contributions to 457(b) deferred compensation accounts do not qualify.

Commuter Checks

The City of San Francisco offers a limited pre-tax commuter benefit for all employees. (Visit sfgov.org for details.) In addition, there is no limit on the amount of post-tax flexible credits you can allocate toward eligible mass transit commuter costs. Submit receipts with your claim for reimbursement.