CENTERING PEOPLE PLACE & POWER

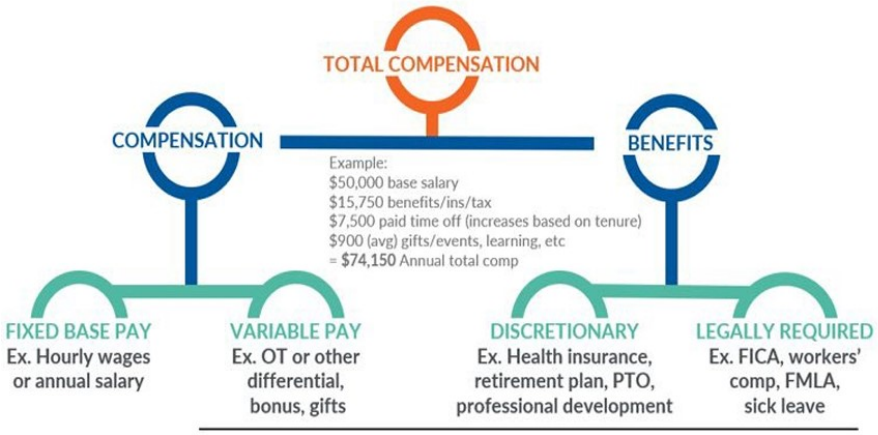
2023–2024 Benefits Guide

What's Inside

This guide provides an overview of the benefits program. It is not intended to be a complete description of the benefits or official summary plan descriptions for these programs. If there is a conflict between this guide and the official plan documents, the plan documents will govern. San Francisco Foundation reserves the right to modify or terminate any of the described benefits at any time and for any reason. The descriptions of these benefits are not a guarantee of current or future employment of benefits. For information about the specific plans available to you, please contact Human Resources.

Compensation Philosophy

What is total compensation?



The San Francisco Foundation (SFF) is committed to paying its employees competitively in a way that reflects responsible stewardship of the foundation's financial assets and complies with existing laws and regulations. We acknowledge and recognize the lived realities of balancing our equity agenda with working in a capitalist system. SFF is committed to making internally fair and equitable pay decisions, both when determining base salary adjustments and when hiring new staff:

- SFF uses a salary structure and job classifications as the framework that guides pay decisions and
- To combat structural pay inequities, we practice negotiation-free salary processes with individual candidates and staff members.
- For initial pay decisions, SFF does not consider tenure or credentials outside of the job description requirements. We assume that an employee's tenure, experience, and/or education are a means of acquiring skills, which in turn result in both job qualifications and performance outcomes and achievement.
- The foundation is committed to paying no less than the San Francisco living wage at the time of the pay structure implementation/adjustment for a single person in a full-time equivalent position. Exceptions may include paid interns.

Your Benefits at a Glance

This is a brief summary of the benefits available to San Francisco Foundation employees. It is provided for quick reference only. Official personnel policies and plan documents govern all benefits and should be referred to for more detailed information. Benefits are subject to change. Eligible employees are consistently scheduled to work at least 30+ hours per week, or are a part-time regular employee working 15-29 hours per week. Eligible dependents include your spouse or domestic partner and your children up to age 26. Click below for details.

SFF Benefits at a Glance Document:

FY24 Classifications

Class I	Class II	Class III	Class IV	Class V	Class VI *New*	Class VII *New*
Full Time 30+ hrs	Part Time 20-29.99 hrs	Full Time 30+ hrs	Part Time 20-29.99 hrs	Part Time Under 20 hrs	Full Time 30+ hrs	Part Time 20-29.99 hrs
Operationally funded, at will	Operationally funded, at will	Scheduled to work 6 months or less, end date	Scheduled to work 6 months or less, end date	Scheduled to work 6 months or less, end date	Scheduled to work over six months, end date	Scheduled to work over six months, end date
Regular	Regular	Temporary	Temporary	Temporary	Limited term	Limited term

San Francisco Foundation: Meet the Team!

Your Human Resources & Administration Team

Hr@sff.org - Adminservices@sff.org - payroll@sff.org

Ayanna Reed
Senior Director of HR and Administration

- Compensation Strategy
- Policy Development
- Learning Design & Strategy
- Diversity, Equity & Inclusion Working Group
- Recruitment

Kristen M. Angel
Manager, HR and Office Administration

- Building Operations Management
- Safety-Injury, Illness & Prevention Plan
- New employee onboarding
- Leaves of absence coordination

Jennifer Benford Seibert
Senior HR Manager

- Internal communications
- Benefits Strategy
- Employee Engagement
- Employee Relations
- Lifecycle Analysis

Angela Marshall
Sr. Administrative Assistant

- Office/Safety supplies and equipment
- Manage vendor relationships
- Office equipment maintenance, training, and troubleshooting

Sofia Puchner
Assistant to the COO and Sr. Director of HR and Administration

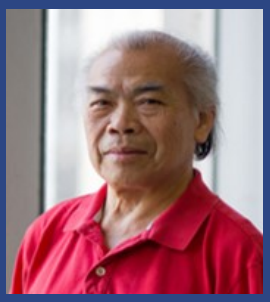
- Scheduling and Calendar Management
- HR Onboarding and SFF University Facilitator
- Contract Management
- Board of Trustees support

Esperanza A. Canes
Receptionist

- Reception
- Mail processing
- Update phone lists and floor plan
- Train admin support staff on front desk ops

Laura Baker
Payroll & Benefits Administrator

- Payroll administration
- ADP system management
- Benefits Administration



Choi Man Wong
Maintenance Assistant

- Assist with furniture assembly and equipment setup
- Maintain inventory of supplies for breakrooms
- Support staff with large convenings
- Outgoing mail

Your Benefits Contacts

Coverage	Contact	Policy Number	Phone	Website
Medical	Blue Shield HMO	W0002801	888-319-5999	www.blueshieldca.com
	Blue Shield PPO	W0002801	888-256-3650	www.blueshieldca.com
	Blue Shield HDHP	W0002801	888-256-3650	www.blueshieldca.com
	Kaiser HMO	39046	800-464-4000	www.kp.org
	Kaiser HDHP	39046	800-464-4000	www.kp.org
Telehealth	Blue Shield	N/A	1-800-835-2362	Teladoc.com/bsc
Dental	Cigna	3341881	800-244-6224	www.mycigna.com
Vision	Cigna	3341881	877-478-7557	www.mycigna.com
Employee Assistance Program (EAP)	IBH Claremont EAP	N/A	800-834-3773	www.claremonteap.com
Life Assistance Program (LAP)	New York Life	N/A	800-538-3543	www.guidanceresources.com WEB ID: NYLGBS
Health Spending Account (HSA)	Health Equity	N/A	866-346-5800	www.healthequity.com
Flexible Spending Account (FSA)	Health Equity	N/A	877-924-3967	www.healthequity.com
Commuter Benefit Plan	Health Equity	N/A	800-733-8839	www.healthequity.com
Life and AD&D	New York Life	Life: SGM606515 AD&D: SOK604609	800-362-4462	www.newyorklife.com
Disability	New York Life	STD: SGD606729 LTD: SGD606730	800-362-4462	www.newyorklife.com
Leave of Absence	Leave Solutions	N/A	800-350-9105	www.leavesolutions.com
401(k) Investment Advice	SageView	N/A	800-814-8742 408-345-2890* (*Personal Appts)	www.sageviewadvisory.com
401(k) Enroll, change, rollover, loans and distributions	Principal	N/A	888-621-5491	www.principal.com
Identity Theft	New York Life	N/A	888-724-2262	www.guidanceresources.com
Pet Insurance	Figo	N/A	844-738-3446	www.figopetinsurance.com
Voluntary Worksite Coverage	Transamerica	N/A	888-763-7474	www.transamericabenefits.com

Your Cost for Health Care Coverage

While San Francisco Foundation pays the majority of the medical, dental, and vision premiums for you and your dependents, you also contribute to your health care premiums. You can select different coverage levels for medical, dental, and vision insurance based on your individual needs.

Your monthly payroll deductions* for medical, dental, and vision coverage are shown in the table below:

Benefit Plan	Employee Only	Employee + Spouse /Domestic Partner*	Employee + Child(ren)	Employee + Family
Medical				
Blue Shield California HMO	$75.00	$150.00	$100.00	$350.00
Blue Shield California PPO	$125.00	$250.00	$150.00	$425.00
Blue Shield California HDHP	$0.00	$100.00	$75.00	$275.00
Kaiser Permanente HMO	$75.00	$150.00	$100.00	$350.00
Kaiser Permanente HDHP	$0.00	$100.00	$75.00	$275.00
Dental				
Cigna PPO	$8.73	$22.16	$21.07	$38.73
Vision				
Cigna	$1.06	$2.04	$2.04	$3.65

***Imputed Income:**

In accordance with the Internal Revenue Code (the U.S. tax code), the IRS requires that any contributions/payments made by an employer towards the cost of covering an employee's DP and/or the DP's child(ren) must be included as taxable income to the employee (sometimes referred to as "imputed income"). In addition to that, any contributions/payments made by an employee towards covering a DP and/or DP's child(ren) must be made with post-tax dollars. Exceptions might apply for the children of registered domestic partners. Employees should consult with their tax advisors for specific tax questions.

Eligibility & Enrollment

Eligibility

You are eligible to participate in the SFF group insurance benefits programs if you are an active or limited term full-time employee working 30 hours per week or active or limited term part-time employees working 15-20 hours per week. Benefits begin on the first of the month following 30 days of employment in an eligible position, subject to the timely submission of your enrolment elections

You may enroll your eligible dependents in many of the same plans you choose for yourself. Proof of dependent status may be required to enroll. Eligible dependents include:

- Your legal spouse or domestic partner
- Your natural, adopted, or stepchildren up to age 26
- Your dependent children of any age, if disabled and incapable of self-support due to mental or physical disability (child must be disabled prior to reaching age 26)

Enrolling & Making Changes

The choices you make when you first become eligible are in effect for the remainder of the plan year July 1 through June 30. It's important to review your benefit options and choose the best coverage for you and your family. You have three opportunities to enroll or make changes:

1. Within 30 days of your eligibility date
2. Within 30 days of a qualified change in family status. Examples include:
   a. Marital status change (marriage, divorce, or legal separation)
   b. Birth or adoption of a child
   c. Death of a dependent
   d. Loss or gain of other health coverage for you and/or dependents.
   e. Change in employment status
   f. Change in Medicaid/Medicare eligibility for you or a dependent
   g. Receipt of a Qualified Medical Child Support Order (or other court order)
3. During the annual enrollment period
4. Other Permissible changes can be made outside of open enrollment - View the Permitted Election Change Event guidance.

Time Off

The SFF provides a variety of time off options to support your work-life balance. We take pride in our flexibility and responsiveness to employee needs during these delicate times.

To augment the required leave protections per local, state and federal guidance, we offer generous leave benefit options.

SFF Internal Paid time off	Leaves under local, state and federal guidance
Paid Holidays	California Paid Family Leave
Paid Personal Days	San Francisco Paid Parental Leave
Vacation Days	Voting Leave
Sick Leaves	Jury Duty
Funeral/Bereavement Leave	Family and Medical Leave
Community Service Day	Pregnancy Disability Leave
Monthly Wellness days; Paid first Friday of the Month Annual Wellness Week (closed first week of January)	

Leave Solutions:

Leave Solutions, our partner for managing leaves of absence. If anticipating a leave of absence or if you just want to know more about the benefits and accommodations process, contact leave solutions. www.leavesolutions.com

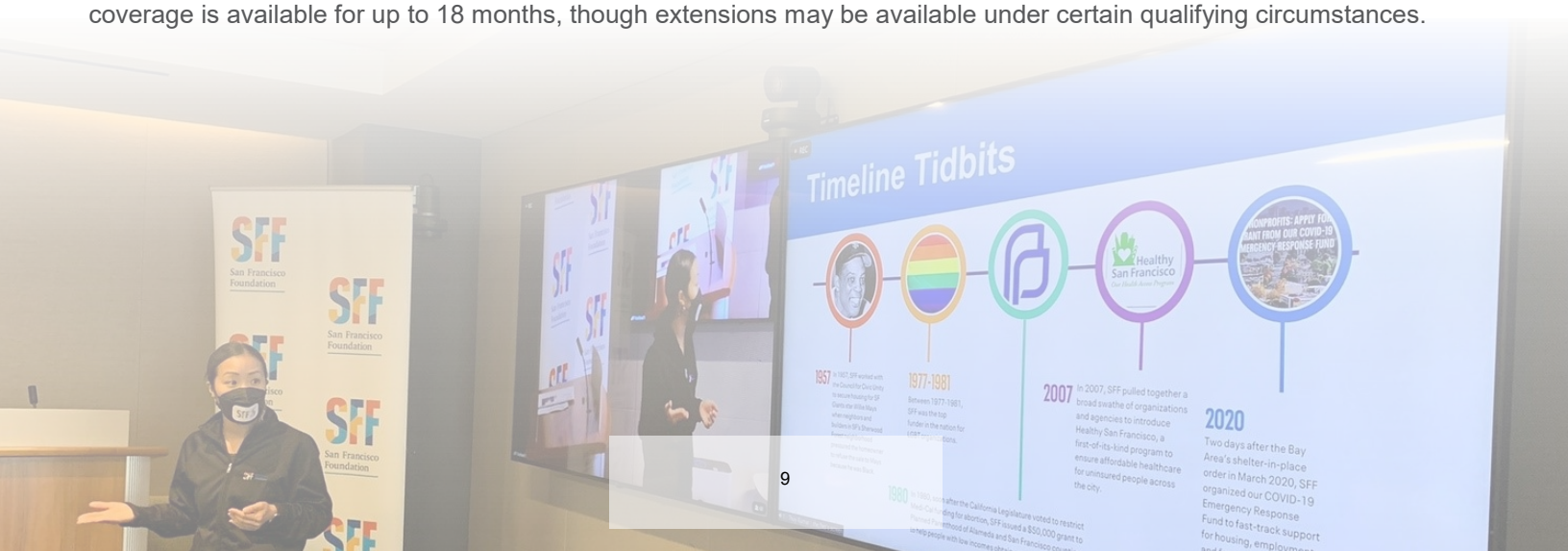
COBRA Coverage: If You Leave Your Job

Your San Francisco Foundation employer-sponsored benefits end on the last day of the month following your termination. You may be eligible to continue coverage for certain benefits for yourself and your dependents as allowed under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

The following benefits qualify for COBRA coverage:

- Medical and Prescription Drug
- Dental
- Vision
- Health Care Flexible Spending

If you participate in COBRA, you must enroll within 60 days of your notification date or coverage end date. You will be responsible for making monthly payments for the full premium, plus a 2% administration fee. In most cases, COBRA coverage is available for up to 18 months, though extensions may be available under certain qualifying circumstances.



We Proudly Offer Flexible Gift of Time Benefits

Check your MS Outlook calendar for updates

Alternative Work Schedule

- The Foundation observes alternating Fridays as day's off with pay. Check your MS Outlook calendar.

No internal meeting Friday

- Check MS Outlook for the most current internal meeting calendar dates.

Gift of Community

Learning Together

- All employees are expected to take advantage of valuable opportunities for the SFF staff to center around and to discuss a prevailing issue or concern. External resources are often brought in to facilitate illuminating discussion around a contemporary theme.

All Staff Meetings

- During these meetings, the staff comes together for organizational updates about the progress of our work and its impact on the communities that we serve.

Matching Donations

- Our employee matching grants program allows regular full-time and part-time employees to request a $2 for $1 match for nonprofit organizations within the five-bay area counties and national nonprofit organizations that have programs/activities that serve the Bay Area. In addition we support one paid community service day per month.

- Should you wish to have SFF match your donation to an organization outside of the five Bay Area Counties please do so by completing the necessary steps in Fluxx, http://sff.fluxx.io/user_sessions/new

- You can contribute to organizations with 501(c)(3) designation or that fiscally sponsored by a 501(c)(3) organization.

Community Service for you or your team

- Is there a local non-profit that you would like to support with your time? The foundation allows eligible employees to donate up to one day / month in community service. Just initiate your request in ADP and submit during the pay-cycle that you are using the time to support your cause.

Work from Any Where Policy:

- Recognizing the benefits of flexible work arrangements and in furtherance of more flexibility around summer and holiday travel, beginning July 1, 2022, eligible employees are able to temporarily work from a location other than their primary assigned work location for up to four (4) weeks/ (20) days per fiscal year.

Education Assistance (Refer to the SFF Employee Handbook for more information)

- We feel individuals who possess a desire to continue their education in addition to performing their full-time job show a commitment to improving themselves and their position within The Foundation. To encourage and reward these individuals, The Foundation offers an Education Assistance benefit.
- In addition your department or team may participate in team building community service activities as well.

San Francisco Foundation University

SFF University is a 4-5 week program aimed to enhance new hires' onboarding experience. New Hires will become familiar with institutional information, values and goals, supporting success and emergence into the SFF culture.

Most employees complete all sessions within the first 4 months of employment. Sessions are generally held weekly on Wednesdays from 2pm-5pm during the cohort curriculum window.

Curriculum Topics Include:

- SFF History, Structure, Equity Agenda
- Information Technology
- Working Norms
- Processes and external contracts
- Community Foundations
- Internal Equity Working Group
- Finance
- Community Reflections

Affinity Groups: What is an Affinity Group? Affinity Groups (aka Employee Resource Groups) are organic collectives of employees who meet to discuss mutual and shared interests aligned with each respective group.

While SFF Affinity Groups are not financially supported by the administration, we want to ensure that our efforts to be inclusive include sharing information about ways to exchange ideas and participate in discussions available to the community of employees.

The composition of the groups changes periodically. Individuals participating in these groups are expected to adhere to the SFF Code of Conduct.

Contact the coordinators noted for more information about the frequency and duration of the meetings. You can find a link to the current Affinity Groups here: 2023 Affinity Group List.docx.

Ready to Enroll?

It's important to review your needs and the needs of your family so you can make the best choices from the options available to you. Follow these steps to enroll in your benefits.

1. **Evaluate Your Needs**

   Be a smart health care shopper and ask yourself the following questions:

   - **Who should I cover?** Evaluate your coverage options for all dependents who meet eligibility requirements.
   - **How much did I spend on health care this past year?** Consider your past expenses to help you plan for the future.
   - **Will I need more or less health care coverage next year?** Estimate the amount of health care you will require in the upcoming year.

2. **Review Your Options**
   - Review this benefits guide to compare your options and evaluate plan costs and potential savings.

3. **Enroll Online for benefits except 401(k) and FSA Transit**
   - Visit https://sffoundation.ease.com/
   - On the Dashboard, click the "Get Started" button.
   - To log in, click the link which will take you to the site and prompt you to create a password. Make sure to keep your password so that you can use it to log in throughout the year to see information about your benefits, change your life insurance beneficiary or change your elections in the event of a "qualifying" work or life event.

4. **Confirm Your Elections**
   - After you submit your elections, review your confirmation statement carefully to make sure your benefits and dependent information are correct.

Ready to Enroll: 401(k) & Commuter

Principal 401(k)

1. Create an account with the Principal
2. Navigate to your options
3. Make your enrollment amount elections
4. Select your investment options
5. Designate your beneficiaries
6. Use other self-service features to support your financial health and worth in retirement.

Health Equity (Commuter Benefits Plan)

1. A Health Equity user account with be created AFTER your enrollment in EASE is complete.
2. You will receive an email from Health Equity inviting you to set up your account.
3. Follow email instructions which you will receive from Health Equity within 30 days of your election on EASE.

Helpful Enrollment Tip

Each year you wish to participate in a Flexible Spending Account, Health Savings Account, or Commuter Plan, you must designate the amount you want to contribute to each account from your paycheck up to annual IRS limits.

Valuable Health & Well-being Resources

Employee Assistance Program (EAP)

When you need help with work, home, personal, or family issues, the Employee Assistance Program (EAP) through Claremont and Life Assistance Program (LAP) through New York Life offers value-added programs and services at no charge.

San Francisco Foundation employees and their household family members can access this confidential service through Claremont to help with many life challenges including elder care, illness, grief and loss, stress and depression, financial counseling, family challenges, legal matters, and much more. These services can help you overcome challenges while saving you both time and money.

The EAP gives you access to:

- Unlimited phone sessions
- Up to five free counseling visits per issue, per person, per year
- Childcare and elder care assistance
- Financial services assistance
- Up to 30-minute free legal consultation by phone or person
- Identity theft recovery services
- Concierge services
- Work/life services

Contact Claremont EAP anytime, day or night, by calling 800-834-3773 or by visiting www.claremonteap.com.

Life Assistance Program (LAP)

The New York Life LAP gives you access to:

- Visit a specialist: Includes three face-to-face sessions for you and members of your household
- Reward Yourself: Access to Healthy Rewards discount programs for discounts on a range of health and wellness service
- Legal Consultation: Receive a 30-minute free consultation and up to a 25% discount on select fees
- Parenting: Guidance on child development, sibling rivalry, separation anxiety and more
- Senior Care: Learn about challenges and solutions associated with caring for an aging loved one
- Child Care: Whether you need care all day or just after school, find the place that's right for your family
- Pet Care: From grooming to boarding to vet services

Contact New York Life LAP anytime, day or night, by calling 800-538-3543 or visiting www.guidanceresources.com

Health Benefits

Helpful Benefit Terms & Definitions

To better understand your coverage, it's helpful to be familiar with benefits vocabulary. Take a moment to review these terms, which may be referenced throughout this guide.

Balance Bill — When a health care provider bills a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge.

Copay — A fixed dollar amount you pay the provider at the time of service; for example, a $25 copay for an office visit or a $10 copay for a generic prescription.

Coinsurance — The percentage paid for a covered service, shared by you and the plan. Coinsurance can vary by plan and provider network. Review the plans carefully to understand your responsibility. You are responsible for coinsurance until you reach your plan's out-of-pocket maximum.

Deductible — The amount you pay each calendar year before the plan begins paying benefits. Not all covered services are subject to the deductible; for example, the deductible does not apply to preventive care services.

Emergency Room Care — Care received at a hospital emergency room for life-threatening conditions.

In-Network Care — Care provided by contracted doctors within the plan's network of providers. This enables participants to receive care at a reduced rate compared to care received by out-of-network providers.

Out-of-Network Care — Care provided by a doctor or at a facility outside of the plan's network. Your out-of-pocket costs may increase and services may be subject to balance billing.

Out-of-Pocket Maximum — The maximum amount you pay per year before the plan begins paying for covered expenses at 100%. This limit helps protect you from unexpected catastrophic expenses.

Premium — The complete cost of your plans. You share this cost with your employer and pay your portion through regular paycheck deductions.

Preventive Care — Routine health care including annual physicals and screenings to prevent disease, illness, and other health complications. In-network preventive care is covered at 100%.

Primary Care — Care provided by a general practice physician or pediatrician for preventive care and the treatment of common ailments.

Specialty **Care —** Care provided by a physician who treats specific medical or metal health conditions

Urgent Care — Urgent care is not the same as emergency care. Visit urgent care for sudden illnesses or injuries that are not life-threatening. Urgent care centers are helpful when care is needed quickly to avoid developing more serious pain or problems.

Benefit Acronyms

AD&D = Accidental Death & Dismemberment

CDHP = Consumer Driven Health Plan

EOI = Evidence of Insurability

FSA = Flexible Spending Account

LPFSA = Limited Purpose Flexible Spending Account

HMO = Health Maintenance Organization

HRA = Health Reimbursement Account

HSA = Health Savings Account

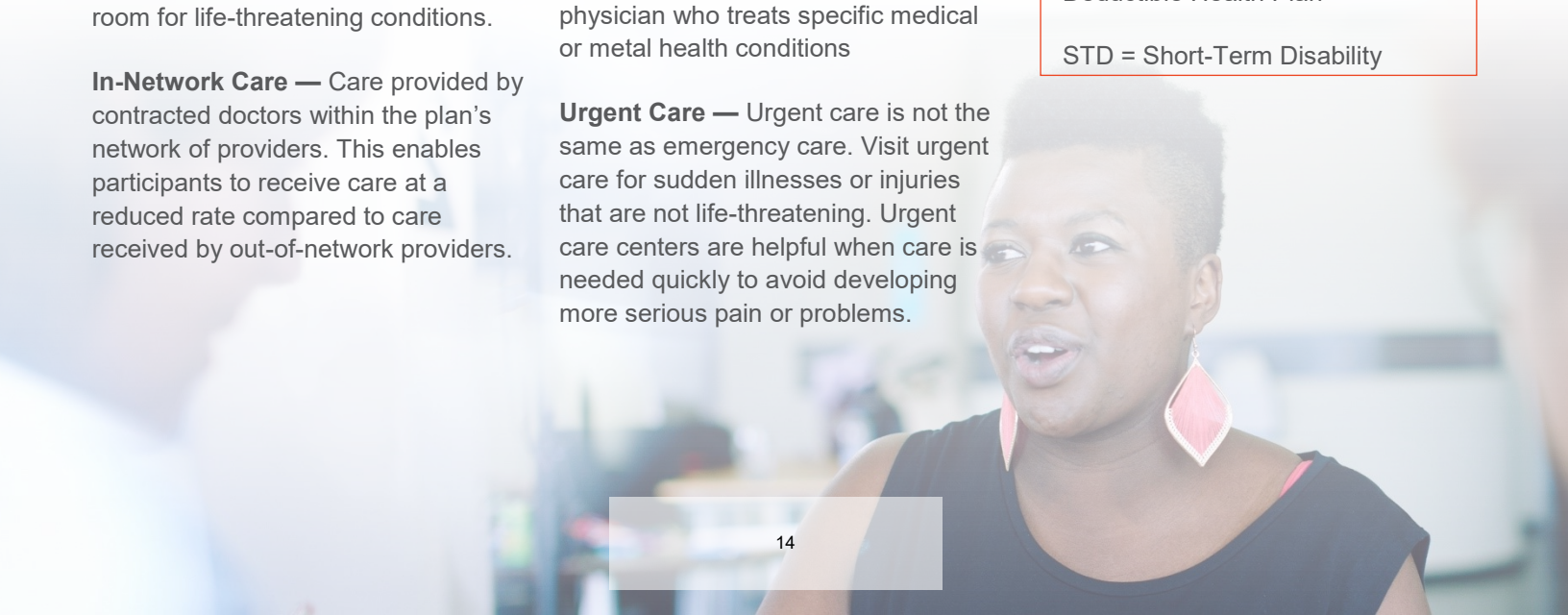
LTD = Long-Term Disability

OOPM = Out-of-Pocket Maximum

PPO = Preferred Provider Organization

QHDHP = Qualified High Deductible Health Plan

STD = Short-Term Disability



Make the Most of Your Medical Plan

Having medical coverage is only the beginning. When you understand the full value of benefits, you'll have everything you need to enjoy good health and save time and money.

Here are some tips to help you take full advantage of your plan benefits:

- Know how to use your plan. Located in-network providers that not only save you money but also help control the overall costs of your medical plan.
- Get the right care at the right time. Use telehealth or visit local urgent care facilities before going to the emergency room in non-critical situations to cut down on costly ER visits.
- Take advantage of the plan's preventive care benefits. Maintaining your health includes getting a regular physical or check-up.
- Use generic drugs. Ask your doctor if you can use a lower-cost alternative for your brand-name prescription drugs.
- Get your prescriptions delivered. If you're on daily maintenance medication for a chronic health condition, use the mail order program to get your prescription shipped right to your door.

Which Medical Plan Is Right for You?

At San Francisco Foundation, our goal is to help you reach your highest potential and be the best version of yourself. This starts with taking care of your overall health. Choosing the right plan to meet your needs is the first step to living your healthiest life.

When deciding which medical plan is right for you and your family, it is important to consider the total cost of overage. This includes what you pay in premiums and what you pay for services out of your pocket.

While each medical plan covers in-network preventive screenings in full, the plans vary on annual deductibles, copays, and levels of coinsurance. This means you may pay higher out-of-pocket costs with one plan versus another. The ideal medical plan should cover most of your health needs with out-of-pocket costs that meet your budget.

Explanation of Medical Plan Options

Health Maintenance Organization (HMO) Plan

With an HMO plan, you select a Primary Care Physician (PCP) who will coordinate your health care needs, including referrals to specialists. You typically pay a flat dollar amount (copay) for qualified health care services. The HMO plan offers in-network coverage only. If you visit a provider outside of the plan's network, you will be responsible for the full cost of services.

Preferred Provider Option (PPO) Plan

A PPO plan gives you the option to seek medical treatment from a contracted medical provider, at negotiated rates, or from an out-of-network provider, at an additional cost. You may pay a copay for select services, with the exception of preventive care, which is covered in full. Other services may be subject to the annual deductible and coinsurance. Once you reach the out-of-pocket maximum, the plan will pay 100% for all eligible expenses for the remainder of the plan year. While you can visit any doctor, you'll save the most money by using in-network providers.

Qualified High Deductible Health Plan (HDHP) with Health Savings Account (HSA)

With the QHDHP, you can receive medical services from in-network or out-of-network providers. You pay for all medical services until you reach the annual deductible, except for in-network preventive care which is covered in full. After your annual deductible is met, the plan pays for a percentage of covered services known as coinsurance. When you reach the out-of-pocket maximum, the plan will pay 100% for all eligible expenses for the remainder of the calendar year.

When you enroll in the QHDHP, you are eligible to open a Health Savings Account (HSA) to help pay for eligible health care expenses (deductibles, coinsurance, and prescriptions) with pre-tax dollars. See the How the Health Savings Account (HSA) Works section in this guide for more information.

Telemedicine Care Whenever You Need It

Blue Shield

No charge
Call 1-800-Teladoc (835-2362)
Online at Teladoc.com/bsc

Kaiser

No charge
Call 1-866-454-8855
Online at
healthy.kaiserpermanente.org

Plan Highlights

Benefit	HMO	PPO	HDHP w/ HSA
Primary Care Physician required	✓		
Referrals needed for specialist	✓		
Annual deductible to satisfy		✓	✓
Copay for services	✓	✓	
Coinsurance for services		✓	✓
In-network coverage	✓	✓	✓
Out-of-Network coverage		✓	✓
Eligible to enroll in an HSA			✓
Eligible to enroll in Health Care FSA	✓	✓	

Prescription Drug Coverage

Prescription drug coverage is included in the medical plan you select. Regardless of which plan you choose, you'll save the most money by using a participating pharmacy. You can access a list of pharmacies through your plan's website or by calling member services.

Telemedicine: 24/7 Care at Your Convenience

Skip the waiting rooms and scheduling hassles. Telemedicine services through Blue Shield and Kaiser puts you in control of when and where you access care. For just a simple copay, you may speak with a licensed physician, psychologist, or psychiatrist 24/7/365 via phone or computer. These phone consultations and online video visits give you direct access to a licensed medical professional who may be able to:

- Define treatment of common medical conditions, such as colds, flu, bronchitis, allergies, rashes, depression, and more
- Provide specialist referrals
- Prescribe medication

To schedule an appointment with Blue Shield, call 1-800-Teladoc (835-2362) or go online to Teladoc.com/bsc.

To schedule an appointment with Kaiser, call 1-866-454-8855 or go online and to healthy.kaiserpermanente.org.

Your Medical Plan Options

Plan Features	Kaiser HMO	Blue Shield HMO
	In-Network Only	In-Network Only
Calendar Year Deductible Individual/Family	None	None
Calendar Year Out-of-Pocket Maximum Individual/Family	$1,500 / $3,000	$2,000 / $4,000
		You pay:
Preventive Care Visit	No charge	No charge
Primary Care	$20 copay	$20 copay
Telemedicine Visit	No charge	No charge
Specialist Visit	$20 copay	$40 copay
Lab & X-ray	No charge	$30 / $10 ($30 complex)
Urgent Care	$20 copay	$20 copay
Emergency Room (copay waived if admitted)	$100 copay	$200 copay
Outpatient Services	$20 copay	$150 copay
Inpatient Services	$250 / admit	$500 / admit
Infertility Services	50%	Not covered
Chiropractic	$10 copay (up to 30 visits per year)	$15 copay (up to 20 visits per year)
Acupuncture	$10 copay	$15 copay
Prescription Drugs: Retail (up to a 30-day supply)		
Tier 1	$10 copay	$5 copay
Tier 2	$30 copay	$15 copay
Tier 3	$30 copay	$25 copay
Tier 4	20% to $250	20% to $250
Prescription Drugs: Mail Order (up to a 100 day supply)		
Tier 1	$20 copay	$10 copay
Tier 2	$60 copay	$30 copay
Tier 3	$60 copay	$50 copay
Tier 4	N/A	N/A

Your Medical Plan Options Continued

Plan Features	Blue Shield PPO	
	In-Network	Out-of-Network
Calendar Year Deductible Individual/Family	$250 / $500	$1,000 / $2,000
Calendar Year Out-of-Pocket Maximum Individual/Family	$4,300 / $8,600	$8,600 / $17,200
	You pay:	
Preventive Care Visit	No charge, deductible waived	Not covered
Primary Care	$15 copay, deductible waived	40% after deductible
Telemedicine Visit	No charge, deductible waived	Not covered
Specialist Visit	$30 copay, deductible waived	40% after deductible
Lab & X-ray	$15 / $30 copay, deductible waived (10% after deductible complex)	40% after deductible
Urgent Care	$15 copay deductible waived	40% after deductible
Emergency Room (copay waived if admitted)	$150/ visit plus 10% after deductible	
Outpatient Services	$100 copay, 10% after deductible	40% after deductible ($350 / day)
Inpatient Services	10% after deductible	40% after deductible ($2,000 / day)
Infertility Services	Not covered	Not covered
Chiropractic	$10 copay, deductible waived (up to 20 visits per year)	50% after deductible (up to 20 visits per year)
Acupuncture	$25 copay after deductible	40% after deductible
Prescription Drugs: Retail (up to a 30-day supply)		
Tier 1 Tier 2 Tier 3 Tier 4	$5 copay $30 copay $50 copay 30% to $250	Not covered
Prescription Drugs: Mail Order (up to a 100 day supply)		
Tier 1 Tier 2 Tier 3 Tier 4	$10 copay $60 copay $100 copay N/A	Not covered

Your Medical Plan Options Continued

Plan Features	Blue Shield HDHP		Kaiser HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible Individual/Ind. In Family/ Family	$1,750/$3,000 /$3,500	$3,500/$6,000 /$7,000	$2,000/$3,000 /$4,000	
Calendar Year Out-of-Pocket Maximum Individual/Family	$3,300/$6,600	$6,600/$13,200	$3,500/$7,000	
Annual H.S.A. Funding	$800 Annually		$800 Annually	
	You pay:			
Preventive Care Visit	Covered in Full	Not covered	Covered in full	Not covered
Primary Care	15% coinsurance	40% coinsurance	$30 copay	Not covered
Telemedicine Visit	No charge, deductible waived	Not covered	No charge, after plan deductible	Not covered
Specialist Visit	15% coinsurance	40% coinsurance	$50 copay	Not covered
Lab & X-ray	15% coinsurance	40% coinsurance	$10 copay	Not covered
Urgent Care	15% coinsurance	40% coinsurance	$30 copay	Not covered
Emergency Room (copay waived if admitted)	$150 copay + 15% coinsurance		$100 copay, after plan deductible	
Outpatient Services	15% coinsurance	40% coinsurance	$150 copay	Not covered
Inpatient Services	15% coinsurance	40% coinsurance	$250 copay	Not covered
Infertility Services	Not covered	Not covered	Not covered	Not covered
Chiropractic	15% coinsurance	40% coinsurance	$15 copay (up to 20 visits per year)	Not covered
Acupuncture	15% coinsurance	40% coinsurance	$15 copay (up to 20 visits per year)	Not covered
Prescription Drugs: Retail (up to a 30-day supply)				
Tier 1 Tier 2 Tier 3 Tier 4	$10 copay $30 copay $50 copay 30% (up to $250)	Not covered	$10 copay $30 copay 20% (up to$250)	Not covered
Prescription Drugs: Mail Order (up to a 100 day supply)				
Tier 1 Tier 2 Tier 3 Tier 4	$20 copay $60 copay $100 copay 30% (up to $500)	Not covered	$20 copay $60 copay Not covered	Not covered

Navigating Care: Find the Right Care Level for You

$
Telehealth/Virtual Visit
(Non-Life-Threatening)

Benefit:

- Lower cost
- Speak to a doctor from anywhere
- Reduce waiting room time

Reasons to go:

- Headaches
- Fever & flu symptoms
- Cough, cold & sore throat
- Skin irritations & rashes, contagious conditions like “pink eye”
- Counseling services
- Psychiatry services

$$
Primary Care Provider (PCP)
(Non-Life-Threatening)

Benefit:

- In-person examination
- Reasonable price in-network
- Familiarity with regular PCP

Reasons to go:

- Earaches and infections
- Headaches
- Regular treatment for chronic conditions
- Skin irritations & rashes

$$$
Urgent Care Center
(Non-Life-Threatening)

Benefit:

- Lower cost than an ER visit
- Same-day visits often available

Reasons to go:

- Earaches & infections
- Minor cuts, bumps, sprains & burns
- Fever & flu symptoms
- Allergic reactions
- Animal bites
- Mild asthma
- Headaches
- Urinary tract infections
- Back & joint pain

$$$$
Emergency Room
(Life-Threatening)

Benefit:

- Necessary for life-threatening conditions

Reasons to go:

- Sudden numbness or weakness
- Disorientation or difficulty speaking
- Sudden dizziness or loss of coordination
- Seizure or loss of consciousness
- Shortness of breath or severe asthma attack
- Head injury or major trauma
- Blurry or lost vision
- Sever cuts or burns
- Overdoses
- Uncontrolled bleeding
- Coughing or vomiting blood
- Heart attack or chest pain
- Severe allergic reactions

Dental Coverage: Enhance Your Smile

High-quality dental care enhances your overall health. Our dental plans help you maintain a healthy smile through regular preventive dental care and offers coverage to fix problems as soon as they occur. When choosing a plan, consider your anticipated dental needs, as well as the network, deductibles, copays, and services each plan covers. Review your dental plan options to determine which plan is best for you and your family. To find an in-network provider, visit www.mycigna.com.

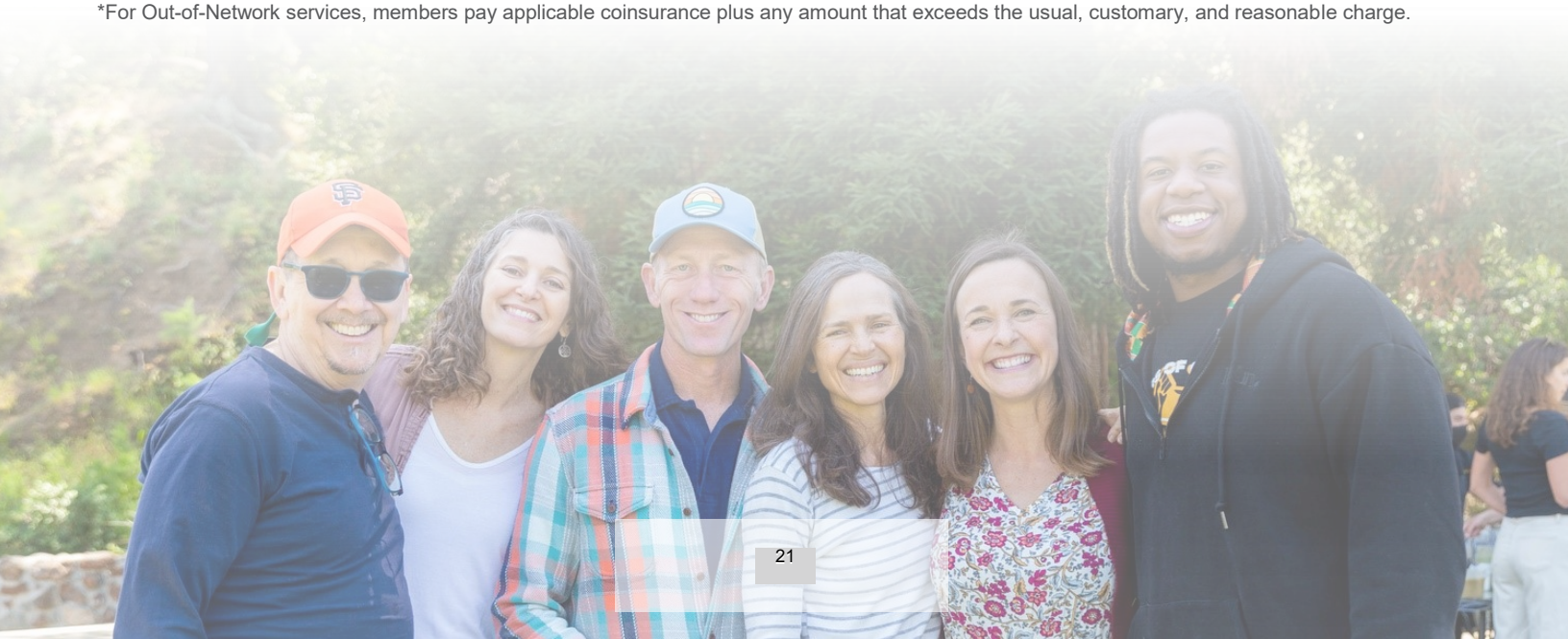
Explanation of Dental Plan Options

PPO Dental Plan

With the PPO dental plan, you may visit any dentist of your choice. Keep in mind, you'll receive the highest coverage when you use an in-network provider. If you visit an out-of-network provider, you will not benefit from discounted rates and will pay more out-of-pocket for services. Many dentists outside the provider network will require you to pay for services upfront and submit forms for reimbursement from your plan.

Plan Features	Cigna PPO Dental Plan	
	In-Network	Out-of-Network*
	You pay:	
Calendar Year Deductible (waived for Preventive Services)	$50 Individual / $150 Family	
Calendar Year Benefit Maximum	WellnessPlus rewards you for getting preventive dental care. Your annual maximum increases each calendar year you receive preventive services from $1,500 to $1,650, $1,800, $1,950	
Diagnostic and Preventive Services (e.g., X-rays, cleanings, exams)	No charge, no deductible	
Basic and Restorative Services (e.g., fillings, extractions, root canals)	10% after deductible	
Major Services (e.g., dentures, crowns, bridges)	40% after deductible	
Orthodontia (child & adult)	50% deductible waived	
Orthodontia Lifetime Maximum	$1,500 (Life time Maximum Combined for In and Out-of-Network)	

*For Out-of-Network services, members pay applicable coinsurance plus any amount that exceeds the usual, customary, and reasonable charge.



Vision Coverage: For a Clear Future

Keep your vision clear and your eyes in good health with regular eye exams. Cigna vision coverage offers an extensive network of optometrists and vision care specialists. You'll save money by visiting Cigna in-network providers. Find an in-network provider online at www.mycigna.com.

Plan Features	Cigna Vision Plan	
	In-Network Only	Out-of-Network
	You pay:	Plan reimburses you:
Exam every 12 months	$20 copay	Reimbursed up to $45
Frames every 24 months	$180 allowance	Reimbursed up to $100
Lenses every 24 months		
Single Vision	$20 copay	Up to $32
Bifocal	$20 copay	Up to $55
Trifocal	$20 copay	Up to $65
Lenticular	$20 copay	Up to $80
Contact Lenses (in lieu of lenses and frames) every 24 months		
Elective	$180 allowance	Reimbursed up to $144
Medically Necessary	$0 copay	Up to $210

How to Find an In-Network Provider

An important consideration when selecting an insurance plan is whether your provider is in the plan's network. Visiting in-network providers offers significant cost savings, and reduces administration for you so it's important to look at the carrier's provider listings before you seek care. Find out if your doctor is in-network or discover new provider options by clicking on the carrier links below or by downloading the carrier's app for quick and easy access while on the go.

Keep in mind: HMO plans offer in-network care only.

How to Find a Blue Shield Provider

- Log on to www.blueshieldca.com
- Select "Find a Doctor"
- Enter your search criteria

How to Find a Kaiser Provider

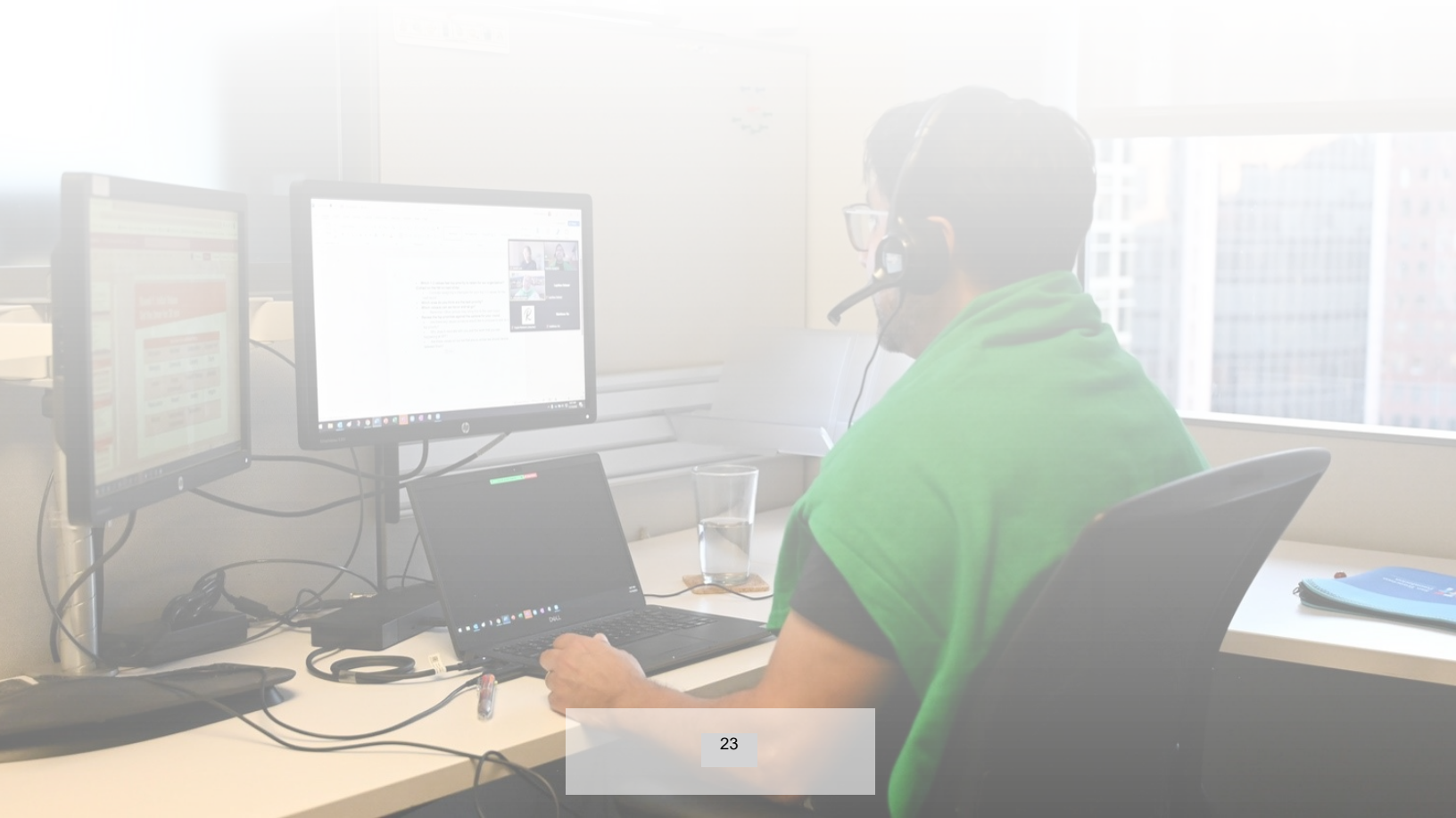
- Log on to www.kp.org
- Select "Find a Doctor"
- Enter your search criteria

How to Find a Dental Cigna Provider

- Log on to www.mycigna.com
- Select "Find a Doctor"
- Enter your search criteria

How to Find a Vision Cigna Provider

- Log on to www.mycigna.com
- Select "Find a Doctor"
- Enter your search criteria



What's in the fine print?

FSAs offer tax advantages, but are subject to IRS regulations:

- All expenses for the Health Care and Dependent Care Flexible Spending Accounts must be incurred during the plan year: July 1 through June 30.
- The IRS has a strict "Use-It or Lose-It" rule for FSAs.
- At the end of the plan year, participants can roll over the remaining balance of unused health care funds. Any remaining funds above this amount will be forfeited.
- Once you enroll in the FSA, you can only change your contribution amount if you experience a qualified status change.
- Each account functions separately. You cannot transfer funds from one FSA to another.
- You must re-enroll in the FSA every year.

Commuter Benefit Plan: Use Pre-Tax $300 for Your Work Commute

The commuter benefits program, administered by Health Equity allows employees who commute to and from work to set aside pre-tax funds to pay for their work-related mass transit and parking expenses. Eligible expenses for the transit benefit include transit passes, fare cards, ticket books, and vanpool expenses.

You may deduct pre-tax money from your paycheck to pay for commute-related expenses which reduces your taxable income. The maximum contribution is:

- Transit: $300 monthly
- Parking: $300 monthly

Financial Benefits

Flexible Spending Accounts (FSAs) – Save Money by Planning Ahead

Flexible Spending Accounts (FSAs), administered by Health Equity, allow you to set aside pre-tax dollars to pay for eligible health and dependent care expenses. As an eligible employee, you may choose to enroll in one or both Flexible Spending Accounts. Each year, you must elect the annual amount you want to contribute to each account. Your contributions will be deducted pre-tax from your paycheck which can help reduce your taxable income.

Health Care FSA: IRS Annual Maximum $3,050/ year

Your Health Care FSA will reimburse you for eligible expenses that you, your spouse/domestic, and your children incur during the plan year. The entire annual amount you elect can be used at any time during the plan year even though your contributions are deducted each paycheck. When you incur an eligible expense, you can use your Infinisource debit card or pay out-of-pocket and submit a reimbursement request with documentation.

Eligible expenses include copays, coinsurance, deductibles, orthodontia, glasses/contact lenses, and much more. For a complete list, refer to IRS Publication 502: Medical and Dental Expenses, available at **www.irs.gov/publications**.

Limited Purpose FSA: IRS Annual Maximum $3,050/year

QHDHP with HSA participants are eligible to participate in the Limited Purpose Health Care FSA to set aside pre-tax dollars for eligible dental and vision expenses only.

Dependent Care FSA: IRS Annual Maximum $5,000/year

Your Dependent Care (or daycare) FSA lets you use “before-tax” dollars to pay daycare expenses for children age 12 and under, or for elder dependents unable to care for themselves. The care must be necessary for you and your spouse to remain employed. Care may be provided through live-in care, babysitters, or licensed daycare centers. Unlike the Health Care FSA, you can be reimbursed only up to the amount available in your account after your payroll contributions.

Contact

Phone: 877-924-3967

Email: memberservices@healthequity.com

Website: www.healthequity.com

Life and AD&D Insurance: For Peace of Mind

Life and Accidental Death and Dismemberment (AD&D) insurance through New York Life, provides financial security to you and your family if you pass away or become seriously injured.

Basic Life and AD&D Insurance

As an eligible employee, you receive both Basic Life and Basic AD&D insurance equal to 1X your annual earnings to a maximum of $250,000. The cost of Basic Life and AD&D coverage is sponsored by The San Francisco Foundation. Premiums paid on your behalf in excess of $50,000 of Life and AD&D benefit are treated as imputed income.

Voluntary Life and AD&D Insurance

In addition to Basic Life and AD&D, you may buy voluntary Life and AD&D coverage at discounted rates that you may not be able to secure on your own. The chart below describes the amounts of coverage you can buy for yourself, your spouse, and your child(ren).

Benefit Features	Voluntary Life and AD&D Options*		
	Employee	Spouse	Dependent Child(ren) Under age 26
Coverage Options	Increments of $10,000	Increments of $5,000	Increments of $1,000
Maximum	Lesser of five times salary or $500,000	$250,000 not to exceed 50% of the employees benefit	$10,000; under six Months old $500
Guaranteed Issue Amount	$100,000	$25,000	
Guaranteed Issue Period	Within 30 days of benefits eligibility or a qualifying life event		

*Evidence of Insurability (EOI) may be required.

What Is EOI?

Evidence of Insurability (EOI) is the process of providing health information to qualify for certain types of insurance coverage. If you elect voluntary Life and AD&D coverage above the guaranteed issue limit or outside of the guaranteed issue period, you will be required to submit a health questionnaire (in some cases, a physical exam may be required). Your questionnaire will be reviewed by New York Life and you will be notified of their decision directly.

How much voluntary Life and AD&D insurance should I buy?

When deciding how much voluntary Life and AD&D coverage to buy, consider the following three factors:

1. How much will your dependents need to pay debts, such as a mortgage, car loan, or credit card balances?
2. How much do your dependents need to maintain their current standard of living?
3. What kind of future would you like to provide for your dependents or others who depend on you for financial support?

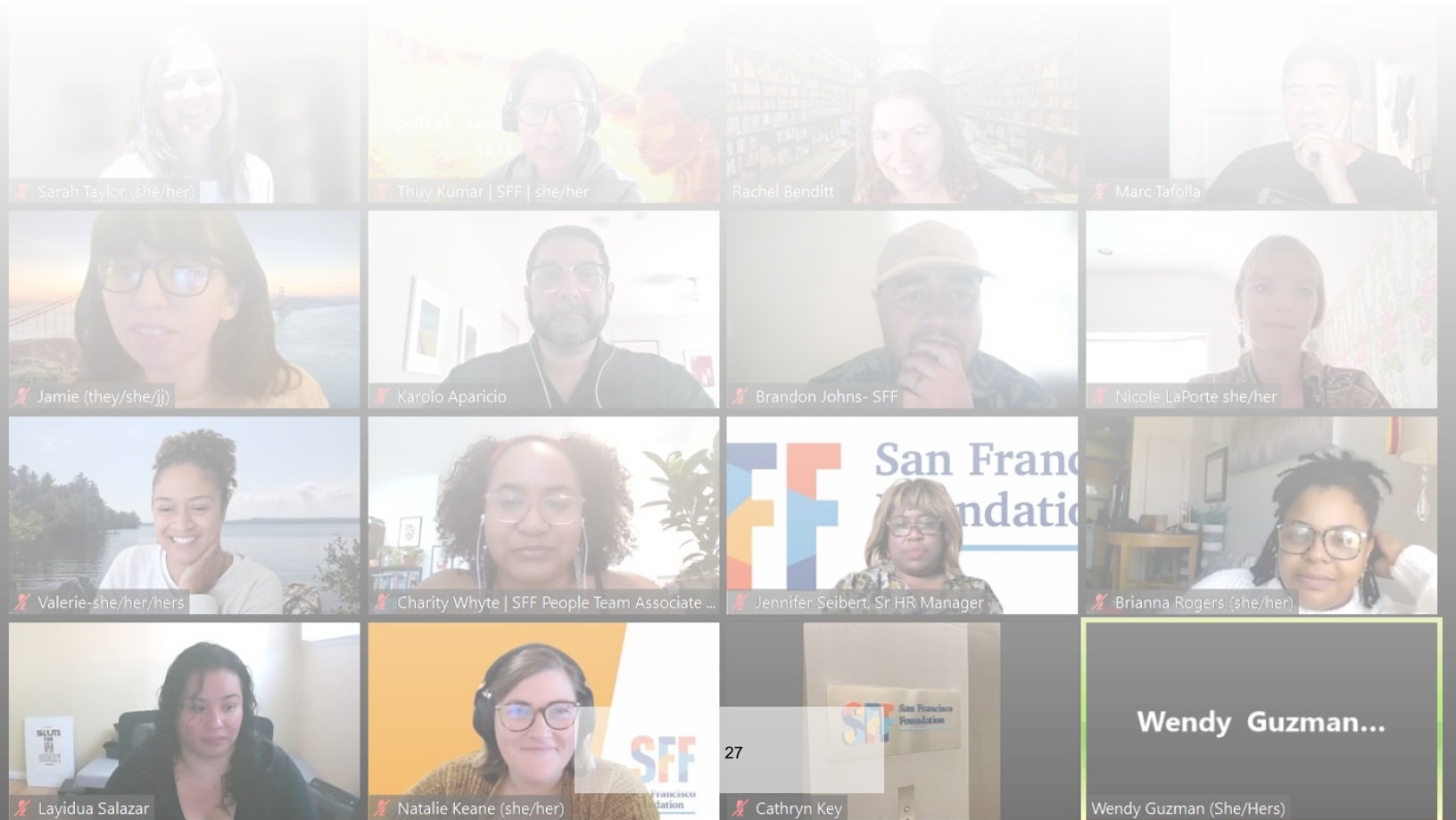
Who should be my beneficiary?

You may choose anyone to be the beneficiary of your Life and AD&D policy in the event of your death or serious injury. Once you select your beneficiary, your designation will remain unchanged until you submit a new beneficiary designation form. We encourage you to periodically review your beneficiary designations to ensure they are up to date and accurate. You may change your beneficiary as often as you wish at www.newyorklife.com by contacting Human Resources.

Voluntary Life and AD&D Insurance Premiums

Voluntary Life Premiums			
Employee		Spouse/Domestic Partner	
EE Age	Per $1,000 of coverage	Spouse/DP Age	Per $1,000 of coverage
Under age 25	$0.060	Under age 25	$0.060
25–29	$0.060	25–29	$0.060
30–34	$0.080	30–34	$0.080
35–39	$0.090	35–39	$0.090
40–44	$0.100	40–44	$0.100
45–49	$0.150	45–49	$0.150
50–54	$0.230	50–54	$0.230
55–59	$0.430	55–59	$0.430
60–64	$0.660	60–64	$0.660
65–69	$1.270	65–69	$1.270
70 +	$2.060	70 +	Spouse coverage ends at 70

Voluntary AD&D Premiums		
Employee	Spouse/Domestic Partner	Child(ren)
$0.020/$1,000 of coverage	$0.020/$1,000 of coverage	$0.200/$1,000 of Vol Life Coverage $0.020 for Optional AD&D coverage



Disability Coverage: Prepare for the Unexpected

Have you considered how you'd pay your mortgage or buy groceries if you are injured or ill and unable to work? If you experience an injury or illness that prevents you from working, disability coverage provides partial income replacement to assist you financially.

Voluntary Short-Term Disability (STD)*

Short-Term Disability coverage, through New York Life, provides you with a portion of income replacement if you are unable to work due to a non-occupational illness or injury. You can purchase additional coverage with the Voluntary Short Term disability program.

The STD plan provides up to 20% of your weekly salary, to a maximum of $1,000 per week for the first 13 weeks of a disability (after a 7- day waiting period).

Table option: Your STD coverage is listed in the table below:

Age Bands:	Rate Table: STD Benefit Per $10 Weekly Benefit
20-54	$0.520
55-59	$0.580
60-64	$0.670
65-69	$0.740

***STD benefits may be offset by benefits you receive from the state-mandated disability plans in California, New Jersey, New York, Rhode Island or the Commonwealth of Puerto Rico.** www.edd.ca.gov*

Long-Term Disability (LTD)

Long-Term Disability coverage, through New York Life, pays you a portion of your earnings if you cannot work for an extended time due to a disabling illness or injury. You are automatically enrolled in LTD at no cost to you.

LTD coverage replaces 66.67% of your base salary to a monthly maximum of $10,000 if you are disabled for more than 90 days and are unable to work. You will continue to receive benefits if you meet the definition of disability or reach your Social Security Normal Retirement Age.

Table option: Your LTD coverage is listed in the table below:

Long-Term Disability (LTD)			
Percentage of Earnings	**Monthly Maximum**	**Elimination Period**	**Maximum Duration**
66.67%	$10,000	90 days	Later of SSNRA or ADEA

Benefits are reduced by other sources of disability income you may qualify for such as Social Security and Workers' Compensation.

401(k) Retirement Plan: Planning for Your Future

Retirement readiness is an important part of overall financial well-being. The San Francisco Foundation Company 401(k) Plan administered by Principal offers a variety of investment options. The San Francisco Foundation will match a certain percentage to help grow and maximize your retirement savings.

Eligibility

All eligible Foundation employees may elect to begin participation in the Company's tax-deferred savings plan (also known as a 401(k) plan) on a quarterly basis. Eligible employees may choose to make Elective Deferrals to the plan at the beginning of the calendar quarter coincident with or following his or her date of hire. The 401(k) Savings Plan was designed to help save for retirement in a tax-effective manner. This Plan helps provide a solid foundation for adding financial security during an employee's retirement years. The 401(k) Plan offers the following advantages and incentives for saving:

Employer Contributions — The Foundation currently contributes 12% (distributed over 24 pay periods) of the employee's base salary after completion of one year of employment and at least 1,000 hours of service. The first 3% is vested immediately. The amount attributable to employer contributions will be fully vested and the remaining nonforfeitable after four years of employment with The Foundation.

Employee Before-Tax Contributions — 401(k) employee contributions may be deducted from your pay before federal and state income taxes are determined.

- **Reduced Federal Income Taxes** — Since taxable income is reduced, employees pay less federal and state income tax resulting in reduced taxable income.
- **Tax-Deferred Growth** — Employee contributions, The Foundation's contributions and all earnings are tax-deferred until the 401(k) account is distributed to the employee.

Employee After-Tax Contributions (Roth Deferrals) — Employees may also be able to avoid the potential for future higher taxation on earnings under the savings plan by designating contributions to the plan as Roth Deferrals. Roth Deferrals are a form of salary deferral but instead of contributing on a post-tax basis, you must make current income tax payments on such deferrals. Provided you satisfy the distribution requirements applicable to Roth Deferrals from the plan, including any amount attributable to earnings; your entire distribution may be withdrawn tax -free.

Enrollment Instructions: Principal 401(k)

1. Create an account with the Principal
2. Navigate to your options
3. Make your enrollment amount elections
4. Select your investment options
5. Designate your beneficiaries
6. Use other self-service features to support your financial health and worth in retirement.

401(k) Fast Facts

- You are eligible to participate in the 401(k) plan at the beginning of the calendar quarter coincident with or following their date of hire
- In 2023, you may contribute up to the IRS maximum of $22,500.
- If you are age 50 or over, you can make "catch-up" contributions up to $7,500.
- The Foundation currently contributes 12% (distributed over 24 pay periods) of the employee's base salary after completion of one year of employment and at least 1,000 hours of service. The first 3% is vested immediately.

Need a Personal 401(k) Appointment Contact?

Sage View Advisors

Call 800-814-8742

Personal Appts: 408-345-2890

Online at www.sageviewadvisory.com

Helpful Tips on Saving for Retirement

- Start saving as soon as possible to grow your retirement account.
- Begin with small contributions, if necessary, and increase contributions over time.
- Make setting aside money for retirement a habit.
- Understand investment returns may fluctuate.
- Let it sit. Avoid penalties by leaving funds in your 401(k) until retirement.
- If you change jobs, you can roll over your retirement account.

Voluntary Benefits: Complete Your Coverage

Voluntary Pet Insurance: Protect Your Pet's Health

Your pets can now receive coverage to stay healthy, too. Voluntary pet insurance helps you be financially prepared, as veterinary bills can add up quickly. With pet insurance from Figo you can save on unexpected veterinary expenses plus optional coverage to help pay for routine veterinary care, such as vaccines, well-being exams, and teeth cleaning.

Visit figopetinsurance.com, to get an instant quote and enroll at any time. Call Figo Pet Insurance at 844-738-3446 to speak with a pet insurance expert if you have any questions.

Worksite Benefits: Extra Protection

Accident Insurance

Accidents can happen any time. As an eligible employee, you can buy Transamerica Accident insurance to help pay for expenses related to unexpected accidents and injuries. Accident insurance pays in addition to your medical plan and benefits are payable regardless of any other insurance plans.

The benefit amount is determined by the injury and medical care received and paid in a lump sum amount. No health questions are required, but a pre-existing condition clause may apply. Employees are responsible for the cost of this benefit and you may sign up for coverage for yourself, your spouse, and your children.

Hospital Indemnity Insurance

An unexpected hospital stay or confinement can be expensive, even with medical insurance. As an eligible employee, you can buy Transamerica Hospital Indemnity insurance to help pay for expenses and bills related to being admitted or confined in a hospital. Benefits are paid directly to you and the funds can be used as you see fit.

No health questions are required, but a pre-existing condition clause may apply. Employees are responsible for the cost of this benefit and it is available for employees, spouses, and children.

Critical Illness Insurance

Are you protected if you experience a critical illness? As an eligible employee, you can buy Transamerica Critical Illness insurance to help pay for expenses related to the diagnosis of a critical illness such as a heart attack, coma, kidney failure, or cancer. Critical Illness insurance pays in addition to your medical plan and benefits are payable regardless of any other insurance plans.

The benefit amount is determined by the type of illness and is paid in a lump sum amount. No health questions are required, but a pre-existing condition clause may apply. Employees are responsible for the cost of this benefit. Coverage is available for employees, spouses, and their children.

Wellness Resources

Employees should self-direct to the wide variety of resources that can support the work-life balance of you and your family. Some opportunities may be offered by more than one of our business partners. Explore the resources which may fit your needs.

- EAP
- Kaiser & Blue Shield offers self-directed resources to address chronic conditions, weight loss management and more.
- Claremont EAP offers professional development opportunities, personal financial planning resources, links to eldercare support and more.
- New York Life offers Identity Theft protection support, personal counseling sessions and more.
- Life Mart offers consumer discounts on entertainment, travel, pet needs and more.

What Is a Pre-Existing Condition?

If there is a health issue you have been treated for prior to the start date of your new policy, that condition may limit the coverage under the new plan.

Value Added Benefits:

Identity Theft Coverage, Feel Secure

Receive the tools, resources, and guidance you need to help you identify, mitigate, or respond to identity theft. The Identity Theft program through New York Life provides you with access to personal case managers who offer step-by-step assistance and guidance if you experience identity theft. You have access to credit monitoring, credit card fraud assistance, and can get help with emergency travel arrangements.

For more information or to enroll in the plan, call 1.888.724.2262 (U.S. and Canada) or 202.331.7635 or visit www.guidanceresources.com

Will Preparation Services:

Online resources to create and execute state-specific wills, power of attorney and a variety of other important legal documents.

For more information or to enroll in the plan, call 1.888.724.2262 (U.S. and Canada) or 202.331.7635

Survivor Assurance Program:

Losing a loved one is difficult. And we understand how challenging it can be for beneficiaries to manage their loved ones insurance benefits among other pressures during such difficult time. That's why as part of NYL GBS survivor assurance program we offer services* to support beneficiaries when they need it most.

For more information, call 800-538-3543 or visit us at www.guidanceresources.com

Secure Travel:

New York Life Group Benefit Solutions (NYLGBS) Secure Travel offers pre-trip planning, assistance while traveling and emergency medical transportation benefits for covered persons traveling 100 miles or more from home. Service is a phone call away 24/7/365.

For more information, call 888-226-4567

Notes


SF
CENTERING
PEOPLE
PLACE &
POWER

The San Francisco Foundation - Annual Notices

Women’s Health & Cancer Rights Act (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the medical plan.

Contact your Human Resources Department for more information.

Patient Protection Notice

HMO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the HMO may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the carrier.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the carrier.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you **must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Website:
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L.104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Medicare Part D – Creditable Coverage

Important Notice from The San Francisco Foundation about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The San Francisco Foundation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The San Francisco Foundation has determined that the prescription drug coverage offered by the San Francisco Foundation Health and Welfare Plan plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th - December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will be affected. For those individuals who elect Part D coverage, drug coverage under the San Francisco Foundation Health and Welfare Plan will end for the individual and all covered dependents.

If you do decide to join a Medicare drug plan and drop your current The San Francisco Foundation coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with The San Francisco Foundation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

For further information, call Jennifer Benford Seibert at 415-477-2783. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The San Francisco Foundation changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Today's Date:	5/25/2023
Name of Entity/Sender:	The San Francisco Foundation
Contact—Position/Office:	Jennifer Benford Seibert
Address:	One Embarcadero Center Suite 1400, San Francisco, CA, 94111
Phone Number:	415-477-2783

MODEL INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE OMB 0938-0990 FOR USE ON OR AFTER APRIL 1, 2011

HIPAA Notice of Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Name: Jennifer Benford Seibert

Title: Senior Human Resources Manager

Phone number: 415-477-2783

Memo Regarding HIPAA Privacy Notice

San Francisco Foundation Health and Welfare Plan

Notice of Privacy Practices

For The Use and Disclosure of Protected Health Information (PHI)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The San Francisco Foundation Health and Welfare Plan is required by law to maintain the privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices (Notice) describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. This Notice also describes your rights with respect to PHI about you.

The Plan is required to follow the terms of this Notice. We will not use or disclose PHI about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice, and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures.

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and Disclosures To Carry Out Treatment, Payment, And Health Care Operations.

The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan also will disclose PHI to The San Francisco Foundation for purposes related to treatment, payment and health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes.

Uses And Disclosures That Require Your Written Authorization.

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you. In addition, your written authorization will be obtained for uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI.

Uses And Disclosures That Require That You Be Given An Opportunity To Agree Or Disagree Prior To The Use Or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and,
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses And Disclosures For Which Consent, Authorization Or Opportunity To Object Is Not Required.

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

1. When required by law.

2. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

3. When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose or reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

4. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

5. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

6. When required for law enforcement purposes (for example, to report certain types of wounds).

7. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Covered Entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

8. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

9. The Plan may use or disclose PHI for research, subject to conditions.

10. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

11. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operation, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to the following officer: Jennifer Benford Seibert, Senior Human Resources Manager, 415-477-2783, One Embarcadero Center Suite 1400San Francisco, CA, 94111. Email - jbenfordseibert@sff.org

Note, however, that a covered entity (generally, a health care provider) must agree to your request to restrict the disclosure of your PHI to a health plan for any health care or operations purpose that relates to a health care item or service that you have paid in full out-of-pocket, or paid in full by a third party (other than a health plan) on your behalf.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set", for as long as the plan maintains the PHI.

· **Protected Health Information** (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

· **Designated Records Set** includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the Covered Entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer: Jennifer Benford Seibert, Senior Human Resources Manager, 415-477-2783, One Embarcadero Center Suite 1400, San Francisco, CA, 94111. Email - jbenfordseibert@sff.org

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of U.S. Department of Health and Human Services.

Right to Amend PHI

You have the right to request the plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to the following officer: Jennifer Benford Seibert, Senior Human Resources Manager.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made:

1. to carry out treatment, payment or health care operations;
2. to individuals about their own PHI
3. prior to the compliance date; or,
4. based on your written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice contact the following officer: Jennifer Benford Seibert, Senior Human Resources Manager.

The Right to Be Notified of a Breach of Unsecured PHI

The Plan is required by law to notify you following a breach of any Unsecured PHI.

The Right to Opt-Out of Fundraising Communications

If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact Jennifer Benford Seibert, Senior Human Resources Manager, to opt-out of fundraising communications if you chose to do so.

A Note about Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or,
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice is effective beginning 05/25/2023 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided (to all past and present participants and beneficiaries) for whom the Plan still maintains PHI.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another Covered Entity, the plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and,
- uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA.

Your Right To File A Complaint With The Plan Or The HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the following officer: Jennifer Benford Seibert, Senior Human Resources Manager, 415-477-2783, One Embarcadero Center Suite 1400, San Francisco, CA, 94111. Email - jbenfordseibert@sff.org

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Whom to Contact For More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer: Jennifer Benford Seibert, Senior Human Resources Manager, 415-477-2783, One Embarcadero Center Suite 1400, San Francisco, CA, 94111. Email - jbenfordseibert@sff.org