2024-2025 BENEFITS

San Francisco Foundation

READY, SET, ENROLL!

CONTENTS

MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

GETTING STARTED

2024-2025 BENEFITS

July 1, 2024
through
June 30, 2025

IMPORTANT NOTE:
This guide is a summary overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan documents including your benefit summaries, summary of benefits and coverage (SBCs) and summary plan descriptions (SPDs). The plan documents determine how all benefits are paid.

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, San Francisco Foundation supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, retirement benefits, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible if you are an active or limited-term full-time employee working 30 or more hours per week or an active or limited-term part-time employee working 20 - 29 hours per week (Classes I, II, VI, VII).

Eligible dependents

- Legally married spouse.
- Registered Domestic Partner (RDP), where applicable by state law, is eligible for coverage if you have completed a Domestic Partner Affidavit.
- Natural, adopted, or stepchildren up to age 26.
- Children of any age who are disabled and depend on you for support (child must be disabled prior to reaching age 26).
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the plan documents for each benefit.

Who is not eligible

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Employees who work less than XX hours per week, temporary employees not on CLIENT NAME payroll, contract employees, or employees residing outside the United States.

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following 30 days. You must enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment, the one time each year that you can make changes to your benefits for any reason. Open enrollment is generally held in May every year, with an effective date of 7/1.

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents(marriage certificates, birth certificates, etc.).

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 30 days after the event. Other Permissible changes can be made outside of open enrollment. View the Permitted Election Change Event guidance.

ENROLLING FOR BENEFITS

MID YEAR CHANGES

- You have year-round access to a summary of your benefits through Employee Navigator.
- Mid year changes should be initiated through Employee Navigator - HR may reach out for additional verification.

EMPLOYEE NAVIGATOR

Employee Navigator is an online system that enables you to make all your benefit decisions in one place. If you don't have access to a computer, you can access the enrollment portal from a tablet or smartphone using the Employee Navigator Mobile app.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting started

- HR will be sending a "Welcome Email" with a link to the Employee Navigator site and instructions on how to register
- REGISTER on the site and proceed to the DASHBOARD
- ADD your personal and dependent information.
- SELECT your benefit plans for the coming year.
- REVIEW your choices and costs before finalizing.

MEDICAL

OUR PLANS

Blue Shield HMO

Blue Shield PPO

Blue Shield HDHP PPO

Kaiser HMO

Kaiser HDHP HMO

Play the Health Lingo Game!

We offer 5 medical plans through Blue Shield and Kaiser.

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Consider a PPO (Preferred Provider Organization) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers

Consider a HDHP (High Deductible Health Plan) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers
- You want tax-free savings on your healthcare costs
- You want to build a savings account for future healthcare costs for you and your eligible family members
- You want an extra way to add to your retirement savings

Consider an HMO (Health Maintenance Organization) if:

- You want lower, predictable out-of-pocket costs
- You like having one doctor to manage your care
- You are happy with the selection of network providers
- You don't see any doctors that are out-of-network
- You have convenient access to Kaiser facilities

UNDERSTANDING PLAN TYPES

San Francisco Foundation offers 3 medical plan types so that you can pick the plan that best fits your budget and healthcare needs.

Some plans (like HMOs) restrict you to in-network doctors. Other plans (like PPOs) allow you to see any doctor, but you will pay a higher coinsurance percentage if the doctor is out-of-network.

	HMO Health Maintenance Organization	**PPO** Preferred Provider Organization	**HDHP** High Deductible Health Plan
Deductible		✓	✓
Out-of-Network Care Covered		✓	✓
Referral Needed to see Specialist	✓		
Must select Primary Care Physician	✓		
Eligible to Enroll in an HSA			✓
Eligible to Enroll in Health Care FSA	✓	✓	
Pros	• More predictable costs	• You can go anywhere, whether in-network or out-of-network	• An HMO, EPO, PPO or POS with a high deductible, but with the advantage of a tax-free Health Savings Account
Cons	• Less flexibility • No out-of-network coverage • May have to select Primary Care Physician	• You pay more for out-of-network providers	• More responsibility for out-of-pocket costs until the deductible is met

Click to play video

All About Medical Plans

Medical plans can seem hard to understand, but once you understand the building blocks you will be able to choose the best plan for you and your dependents.

Medical

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Kaiser HMO	Blue Shield HMO
	In-Network	**In-Network**
Calendar Year Deductible Individual Individual in a Family Family	None	None
Calendar Year Out-of-Pocket Maximum[1,2,3] Individual Individual in a Family Family	 $1,500 $1,500 $3,000	 $2,500 $2,500 $5,000
Office Visit Primary Care Specialist (Access+)	 $20 copay $20 copay	 $20 copay $30 copay
Telemedicine Visit	No charge	No charge
Preventive Services	No charge	No charge
Chiropractic	$10 copay (up to 30 visits/year)	$10 copay (up to 30 visits/year combined w/ acupuncture)
Acupuncture	Not covered	$10 copay (up to 30 visits/year combined w/ chiropractic)
Lab and X-ray	No charge	No charge
Urgent Care	$20 copay	$20 copay
Emergency Room (copay waived if admitted)	$100 copay	$100 copay
Inpatient Hospitalization	$250 copay	$500 copay
Outpatient Surgery	$20 copay	Surgical Center: $100 copay OP Hospital: $300 copay
PRESCRIPTION DRUGS		
Out-of-Pocket Maximum	Combined w/medical	Combined w/medical
Retail Tier 1 Tier 2 Tier 3 Tier 4 Supply Limit	 $10 copay $30 copay N/A N/A 30 days	 $5 copay $10 copay $25 copay 20% up to $250 30 days
Mail Order Tier 1 Tier 2 Tier 3 Tier 4 Supply Limit	 $20 copay $60 copay N/A N/A 100 days	 $10 copay $20 copay $50 copay 20% up to $500 90 days

[1] Out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2] An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[3] All covered expenses, including your prescription copays, accumulate towards the out-of-pocket maximum.

Medical

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Blue Shield PPO	
	In-Network	**Out-of-Network**
Calendar Year Deductible[1,2] Individual Individual in a Family Family	 $500 $500 $1,500	 $1,500 $1,500 $4,500
Calendar Year Out-of-Pocket Maximum[1,3,4] Individual Individual in a Family Family	 $3,000 $3,000 $6,000	 $5,000 $5,000 $10,000
Office Visit Primary Care Specialist	 $15 copay $20 copay	 40%[5] 40%[5]
Telemedicine Visit	No charge	Not covered
Preventive Services	No charge	Not covered
Chiropractic	$15 copay (up to 20 visits/year)	40%[5] (up to 20 visits/year)
Acupuncture	$15 copay (up to 20 visits/year)	40%[5] (up to 20 visits/year)
Lab and X-ray	**Lab:** Lab Center: $15 copay[5] OP Hospital: $40 copay[5] **X-Ray:** OP Radiology: $15 copay[5] OP Hospital: $40/x-ray & imaging[5]	**Lab:** Lab Center: 40%[5] OP Hospital: 40%[5] (max. of $350/day) **X-Ray:** OP Radiology: 40%[5] OP Hospital: 40%[5] (max. of $350/day)
Urgent Care	$15 copay	40%[5]
Emergency Room (copay waived if admitted)	$150 copay + 10%	$150 copay + 10%
Inpatient Hospitalization	10%[5]	40%[5] (max. of $600/day)
Outpatient Surgery	Surgical Center: 5%[5] OP Hospital: 15%[5]	40%[5] (max. of $350/day)
PRESCRIPTION DRUGS		
Out-of-Pocket Maximum	Combined w/medical	Combined w/medical
Retail- 30 Day Supply Tier 1 Tier 2 Tier 3 Tier 4	 $5 copay $10 copay $25 copay 30% up to $250	 $5 copay + 25% $10 copay + 25% $25 copay + 25% 30% up to $250 + 25%
Mail Order- 90 Day Supply Tier 1 Tier 2 Tier 3 Tier 4	 $10 copay $20 copay $50 copay 30% up to $500	Not covered

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2] An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.
[3] An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[4] All covered expenses, including your medical deductibles and prescription copays, accumulate towards the out-of-pocket maximum.
[5] After deductible.

Medical

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Blue Shield HDHP PPO		Kaiser HDHP HMO	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible[1,2] Individual Individual in a Family Family	 $1,600 $3,200 $3,200	 $1,600 $3,200 $3,200	 $2,000 $3,200 $4,000	 $2,000 $3,200 $4,000
Calendar Year Out-of-Pocket Maximum[1,3,4] Individual Individual in a Family Family	 $3,500 $3,500 $7,000	 $6,000 $6,000 $12,000	 $3,500 $3,500 $7,000	 $3,500 $3,500 $7,000
Annual HSA Funding	$800 annually		$800 annually	
Office Visit Primary Care Specialist	 10%[5] 10%[5]	 40%[5] 40%[5]	 $30 copay[5] $50 copay[5]	 Not covered
Telemedicine Visit	No charge	Not covered	No charge[5]	Not covered
Preventive Services	No charge	Not covered	No charge	Not covered
Chiropractic	10%[5] (up to 20 visits/year)	40%[5] (up to 20 visits/year)	$15 copay[5] (up to 20 visits/year)	Not covered
Acupuncture	10%[5] (up to 20 visits/year)	40%[5] (up to 20 visits/year)	Not covered	Not covered
Lab and X-ray	Lab Center/Radiology: 10%[5] OP Hospital: 20%[5]	Lab Center/Radiology: 40%[5] OP Hospital: 40%[5] (max. of $350/day)	$10 copay[5]	Not covered
Urgent Care	10%[5]	40%[5]	$30 copay[5]	Not covered
Emergency Room (copay waived if admitted)	$150 copay + 10%[5]	$150 copay + 10%[5]	$100 copay[5]	$100 copay[5]
Inpatient Hospitalization	10%[5]	40%[5] (max. of $600/day)	$250 copay[5]	Not covered
Outpatient Surgery	Surgical Center: 5%[5] OP Hospital: 15%[5]	40%[5] (max. of $350/day)	$150 copay[5]	Not covered
PRESCRIPTION DRUGS				
Out-of-Pocket Maximum	Combined w/medical	Combined w/medical	Combined w/medical	Combined w/ medical
Retail Tier 1 Tier 2 Tier 3 Tier 4 Supply Limit	 $10 copay $25 copay $40 copay 30% up to $250 30 days	 $10 copay +25% $25 copay + 25% $40 copay + 25% 30% up to $250 +25% 30 days	 $10 copay[5] $30 copay[5] N/A N/A 30 days	 Not covered
Mail Order Tier 1 Tier 2 Tier 3 Tier 4 Supply Limit	 $20 copay $50 copay $80 copay 30% up to $500 90 days	 Not covered	 $20 copay[5] $60 copay[5] N/A N/A 100 days	 Not covered

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2] An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.
[3] An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[4]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[5]After deductible.

MEDICAL CARRIER RESOURCES

Blue Shield Website

You can also use the Blue Shield website to view more helpful resources and educational tools.

Kaiser Website

You can also use the Kaiser website to view more helpful resources and educational tools.

Did you know both Kaiser and Blue Shield offer several programs to help you manage your healthcare? Learn more about them here.

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 to healthy.kaiserpermanente.org.

Wellness Resources

Kaiser and Blue Shield offer self-directed resources to address chronic conditions, weight loss management and more.

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

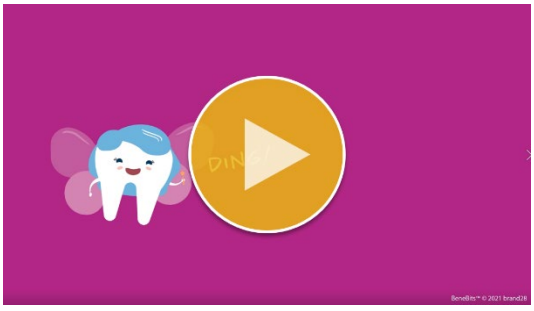
Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit 	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$$$**

DENTAL

OUR PLAN

Cigna PPO Dental Plan (DPPO)

Click to play video



We offer dental coverage through Cigna.

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

Dental

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Cigna DPPO	
	In-Network	**Out-of-Network[1]**
Annual Deductible	$50 Individual / $150 Family	$50 Individual / $150 Family
Annual Plan 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 (Y2), $1,800 (Y3), $1,950 (Y4).	
Waiting Period	None	None
Diagnostic & Preventive	No charge	No charge
Basic Services Fillings Root Canals Periodontics	10%[2]	10%[2]
Major Services	40%[2]	40%[2]
Orthodontia Adults & Children	50%	50%
Ortho Lifetime Max	$1,500	$1,500

[1] For Out-of-Network services, members pay applicable coinsurance plus any amount that exceeds the usual, customary, and reasonable charge.
[2] Deductible applies.

What you need to know about this plan

Features:	DPPO: See any provider, but you might pay more out of network.
Am I restricted to in-network providers?	No
Do I have to select a primary dentist?	No
Can I use my HSA or FSA?	If you participate in a healthcare FSA, limited purpose FSA, or HSA, you can use your account to pay for dental expenses.
Where can I get more details?	Visit my.cigna.com for more information.

VISION

OUR PLAN

Cigna Vision Plan

Click to play video

We offer vision coverage through Cigna.

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription through the Healthy Rewards - Vision Network Savings Program! This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

Vision

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	Cigna Vision Plan	
	In-Network	**Out-of-Network**
Exams		
Benefit	$20 copay	Reimbursed up to $45
Frequency	Once every 12 months	Once every 12 months
Eyeglass Lenses		
Single Vision Lens	$20 copay	Reimbursed up to $32
Bifocal Lens	$20 copay	Reimbursed up to $55
Trifocal Lens	$20 copay	Reimbursed up to $65
Lenticular	$20 copay	Reimbursed up to $80
Frequency	Once every 24 months	Once every 24 months
Frames		
Benefit	$180 allowance + 20%	Reimbursed up to $100
Frequency	Once every 24 months	Once every 24 months
Contacts (in lieu of lenses and frames)		
Elective	$180 allowance	Reimbursed up to $144
Medically Necessary	No charge	Reimbursed up to $210
Frequency	Once every 24 months	Once every 24 months

What you need to know about this plan

Features: See any provider, but you'll pay more out of network

Eyeglasses are expensive. Will I still be able to afford them, even with insurance? Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in a healthcare FSA, limited purpose FSA, or HSA, you can use your account to pay for vision care and eyewear with tax-free dollars.

Where can I get more details? Visit my.cigna.com for more information.

HEALTH SAVINGS ACCOUNT (HSA)

Click to play video

ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the Blue Shield HDHP or Kaiser HDHP HMO.
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for current healthcare expenses and save for future expenses.

How the Health Savings Account works

- Your HSA account is set up automatically after you enroll.
- You can contribute up to the 2024 annual limit set by the IRS:
  Individual: $4,150 per year
  Family: $8,300 per year
  Are you age 55 **or over?** You can contribute an additional $1,000 per year
- To help you get started, San Francisco Foundation makes a contribution to your HSA (this is included in the IRS maximums noted above):
  Individual: $800
- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for current healthcare expenses or save it for future use.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but with no penalties.

Find out more

- If you are enrolled in the Blue Shield HDHP PPO plan, visit the Health Equity site for more information about your HSA account
- If you are enrolled in the Kaiser HDHP HMO plan, visit the Kaiser HSA site for more information about your HSA account
- Eligible Expenses
- Ineligible Expenses

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high deductible health plan (like our Blue Shield HDHP PPO or Kaiser HDHP HMO), you can only participate in the **Limited Purpose FSA** for dental and vision expenses.

Find out more

- HealthEquity.com/Learn/FSA
- Eligible Expenses – now includes more over-the-counter items!
- Ineligible Expenses
- FSA Calculator – This tool can be used to estimate your health spending for the year to help with your FSA elections.

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through Health Equity.

How the Healthcare FSA works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, and even eligible drugstore items.
- You can contribute up to **$3,200**, the 2024 annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- Expenses must be incurred between 7/1/2024 and 6/30/2025, and claims must be submitted for reimbursement no later than 9/30/2025. If you don't spend all the money in your account, you can roll over up to **$640** to use the following year. Any additional remaining balance will be forfeited.
- Elections cannot be changed during the plan year unless you experience a qualifying event.
- You must re-enroll in this program each year.

Limited Purpose FSA

- If you/your spouse are enrolled in a high deductible health plan (like our Blue Shield or Kaiser HSA plans), you can only participate in the Limited Purpose FSA for dental and vision expenses.
- All other considerations listed above also apply to the Limited Purpose FSA.

FSA TAX SAVINGS EXAMPLE (SINGLE FILERS)

$60,000 Annual Pay, with $1,500 FSA Contribution

$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings

$120,000 Annual Pay, with $2,850 FSA Contribution

$684 24% Federal income tax	**$219** 7.65% FICA tax	**$903** Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to $5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on daycare. This program is administered by Health Equity.

Here's how the Dependent Care FSA works

You set aside money from your paycheck, before taxes, to pay for work-related daycare expenses. Eligible expenses include not only childcare but also before and after-school care programs, preschool, and summer day camp for children under age 13. The account can also be used for daycare for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to $2,500 each year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Expenses must be incurred between 7/1/2024 and 6/30/2025, and claims must be submitted for reimbursement no later than 9/30/2025. There are no rollovers for the dependent care FSA. If you don’t spend all the money in your account by the end of the plan year, you forfeit any remaining balance.

Estimate carefully! You can’t change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide short and long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

LIFE AND AD&D INSURANCE

A NOTE ABOUT TAXES

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

EVIDENCE OF INSURABILITY (EOI)

If you elect Voluntary Life coverage above the guaranteed issue (noted on this page) or are a late entrant (enrolling more than 30 days after the date you become eligible), you must complete and submit EOI. This can be completed online through Lincoln Financial. Log in to the MyLincolnPortal.com site to register and complete the EOI.

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by Lincoln (Sourcewell) and premiums are paid in full by San Francisco Foundation.

Lincoln (Sourcewell) Basic Life and AD&D

1x base annual earnings up to a maximum of $250,000.

The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.

Voluntary Life and AD&D

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Lincoln (Sourcewell) and available for your spouse and/or child(ren). Voluntary AD&D Insurance allows you to purchase accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing, the plan pays a benefit to you.

Lincoln (Sourcewell) Voluntary Life and AD&D

Employee	Increments of $10,000 up to 5x base annual earnings or $500,000, whichever is less Guaranteed Issue: $150,000
Spouse	Increments of $5,000 up to $250,000 not to exceed 50% of employee benefit Guaranteed Issue: $30,000
Child(ren)	Increments of $1,000 up to $10,000; Under 6 months old: $500

Note: The guaranteed issue period is 30 days of benefits eligibility or a qualifying life event. The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.

VOLUNTARY SHORT-TERM DISABILITY INSURANCE (STD)

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. You pay the cost of this coverage. Coverage is provided by Lincoln (Sourcewell).

EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

SUBMITTING A CLAIM

If you are disabled due to an illness or accidental injury, unable to work, and under the care of a licensed physician, you are eligible to submit a claim for benefits under this plan. As long as you remain disabled and meet the plan's disability requirements, you will continue to receive a percentage of your earnings until benefits are no longer payable.

Weekly Benefit Amount	Plan pays 20% of weekly earnings
Maximum Weekly Benefit	$1,000
Benefits Begin After Accident Sickness	 30 days of disability 30 days of disability
Maximum Payment Period[1]	13 weeks

[1]Maximum payment period is based on the first day benefits begin, not the first day you are disabled.

Note: 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. Visit edd.ca.gov.

LONG-TERM DISABILITY INSURANCE (LTD)

3 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. San Francisco Foundation pays the cost of this coverage. Coverage is provided by Lincoln (Sourcewell).

Lincoln (Sourcewell) LTD Plan

Monthly benefit amount	60% up to a maximum of $10,000
Benefits begin	After 90 days of disability
Maximum payment period	Later of age 65 or SSNRA

Note: Benefits are reduced by other sources of disability income you may qualify for such as CASDI, Social Security and/or Workers' Compensation.

VOLUNTARY PLANS

OUR VOLUNTARY PLANS

Accident Insurance

Critical Illness Insurance

Hospital Indemnity Insurance

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

San Francisco Foundation offers plans to help:

- replace income if you're injured or ill
- bridge the gap for special healthcare needs
- help manage the costs of hospital stays
- save money on protection for your pets.

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

VOLUNTARY PLANS

THINGS TO CONSIDER

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

Accident Insurance

Accident Insurance from Unum helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

Note: Each member enrolled in the Accident Plan will receive a $75 “Be Well” benefit for receiving their annual physical and submitting the claim!

Critical Illness Insurance

Critical illness insurance from Unum can help fill a financial gap if you experience a serious illness such as cancer, heart attack, or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed.

Note: Each member enrolled in the Critical Illness Plan will receive a $50 “Be Well” benefit for receiving their annual physical and submitting the claim!

Hospital Indemnity Insurance

Hospital indemnity insurance from Unum can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide.

FINANCIAL WELLNESS

PLANS TO HELP YOU SAVE

Transportation & Parking Benefits

401(k) Retirement Savings Plan

Is it time for a “financial wellness” checkup?

Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? And can you even think about preparing for retirement?

Ignoring your financial health can take a toll on your quality of life today and block opportunities for the future. And worrying about money matters can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money now and in the future. You can increase your take-home pay by saving on taxes and work toward your retirement goals.

In addition, Life Mart offers consumer discounts on entertainment, travel, pet needs, and more!

SAVE ON COMMUTE EXPENSES

Transportation Savings Account—up to $315 per month tax-free

Do you have out-of-pocket commuting expenses for public transportation, vanpooling, or worksite parking? If so, you can save on taxes by enrolling in our transportation savings account, administered by Health Equity.

The account lets you set aside money—before it's taxed—through payroll deduction. You may enroll in or stop this program at any time, subject to processing deadlines Money in the account can be used in future months or plan years.

Maximum contribution:

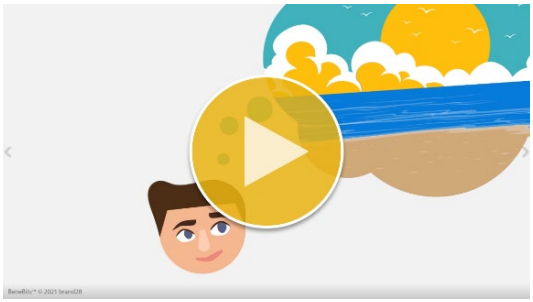
Transit: $315 monthly

Parking: $315 monthly

Note: If you wish to enroll in this plan or make changes, you must do so in the Health Equity portal.

SAVE NOW, ENJOY LATER

Click to play video



WHAT ARE YOUR PLANS?

Many of us can't plan past the weekend, never mind thinking about a retirement nest egg. Our 401(k)-retirement plan will help you set a retirement savings goal and stick to it.

The important thing is to start now and set aside what you can, even if you think it's too small an amount.

With the company match and compound interest, that "small amount" can grow over time. You'll be a retirement saver before you know it.

NEED A PERSONAL 401(k) APPOINTMENT CONTACT?

Sage View Advisors

Call: 800-814-8742

Personal Appts: 408-345-2890

Online at sageviewadvisory.com

401(k) Retirement Savings Plan—up to $23,000 per year (or more)

Our 401(k) Retirement Savings Plan helps you save for retirement. The plan offers tax savings NOW through pre-tax contributions. All regular employees aged 21 and over are eligible to join the plan at the beginning of the calendar quarter coincident with or following their date of hire.

To enroll, visit principal.com and create an account. Make your enrollment amount elections, select your investment options, and designate your beneficiaries. Manage your account, loans and distributions at any time by logging on!

The Principal offers a variety of quality investment options. You'll also have access to special services such as automatic account rebalancing and personal investment assistance from a licensed investment counselor.

Maximum annual contribution limit	Up to $23,000 per year. If you're age 50 or over, save an additional $7,500 per year. IRS limits are evaluated annually and may change.
San Francisco Foundation 401(k) Contributions	SFF provides a discretionary contribution to eligible employees after completing one year of service. The first 3% is vested immediately. Please see the Summary Plan Description for details on when you are vested in (own) contributions from the San Francisco Foundation.

Important differences of a Roth 401(k)

- You pay taxes when you contribute, at your current tax rate.
- Account interest and dividends are not taxed if you meet certain criteria.
- Like a traditional 401(k), you can withdraw money without penalties when you reach age 59½, but you must have held the account for at least 5 years.
- You are not forced to take distributions at age 70½. You can keep the money in your Roth account as long as you want.

WELLBEING & BALANCE

THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT

The challenges of daily life can be hard to balance. Whether it's work, school or family obligations, it's no wonder that many of us sometimes have trouble managing the ups and downs of our day-to-day lives.

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues
- Take time to spend with family and friends, take care of personal business, or just have a little extra "me time".

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

Phone
800-834-3773

Website
claremonteap.com

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Claremont can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 5 visits per issue
- Up to 30-minute free legal consultation by phone or person
- Unlimited web access to helpful articles, resources, and self-assessment tools

COUNSELING BENEFITS

- Difficulty with relationships
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues

LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

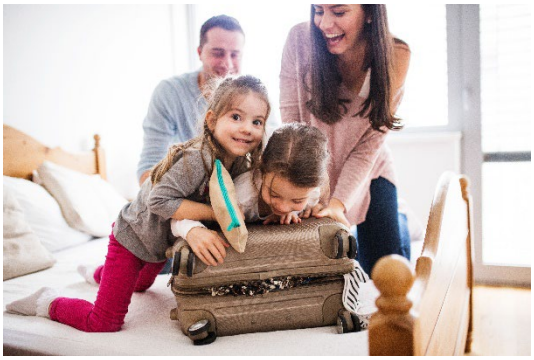
ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

TIME AWAY FROM WORK



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

Leave Solutions is 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, visit 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.

GIFT OF TIME AND COMMUNITY

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 no internal meeting calendar dates.

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.

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. 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.

GIFT OF TIME AND COMMUNITY (cont.)

Education Assistance

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. Refer to the SFF Employee Handbook for more information.

San Francisco Foundation University

SFF University is a 4–5-week program aimed at enhancing 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 to 5pm during the cohort curriculum window.

Curriculum topics include SFF History, Structure, Equity Agenda, Information Technology, Working Norms, Processes and external contracts, Community Foundations, Finance, Community Reflections, and more. Engage in conversation with our CEO, Fred Blackwell.

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 are inclusive, including sharing information about ways to exchange ideas and participating 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: 2024 Affinity Group List.docx.

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your benefit contributions
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify San Francisco Foundation if your domestic partner is your tax dependent.

YOUR MONTHLY BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

MEDICAL

	Kaiser HMO	Blue Shield HMO	Blue Shield PPO	Blue Shield HDHP	Kaiser HDHP HMO
Employee Only	$75.00	$75.00	$125.00	$0.00	$0.00
Employee + Spouse	$150.00	$150.00	$250.00	$100.00	$100.00
Employee + Children	$100.00	$100.00	$150.00	$75.00	$75.00
Employee + Family	$350.00	$350.00	$425.00	$275.00	$275.00

DENTAL

	Cigna DPPO
Employee Only	$8.73
Employee + Spouse	$22.16
Employee + Children	$21.07
Employee + Family	$38.73

VISION

	Cigna Vision Plan
Employee Only	$1.06
Employee + Spouse	$2.04
Employee + Children	$2.04
Employee + Family	$3.65

VOLUNTARY LIFE & AD&D INSURANCE COSTS

If you elect voluntary coverage, your monthly premium rate is calculated based on your age and the amount of coverage. Use the tables below to estimate the premium amount that will be deducted from your paycheck.

VOLUNTARY LIFE INSURANCE – MONTHLY RATE PER $1,000 OF COVERAGE

EE Age	Employee Rate	Spouse Age	Spouse Rate
<25	$0.06	<25	$0.06
25-29	$0.06	25-29	$0.06
30-34	$0.08	30-34	$0.08
35-39	$0.09	35-39	$0.09
40-44	$0.10	40-44	$0.10
45-49	$0.15	45-49	$0.15
50-54	$0.23	50-54	$0.23
55-59	$0.43	55-59	$0.43
60-64	$0.66	60-64	$0.66
65-69	$1.27	65-69	$1.27
70+	$2.06	70+	Coverage ends at 70

VOLUNTARY AD&D – MONTHLY RATE PER $1,000 OF COVERAGE

Employee Only	$0.02
Child(ren)	$0.20 of Vol Life $0.02 of Optional AD&D

VOLUNTARY SHORT-TERM DISABILITY (STD) – WEEKLY RATE PER $10 OF COVERAGE

Age Bands	Rates
<40	$0.148
40-44	$0.155
44-49	$0.160
50-54	$0.162
55-64	$0.180
65-69	$0.186
70+	$0.194

PLAN CONTACTS

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Policy No.
Medical	Blue Shield	HMO: 888-319-5999 PPO/HDHP: 888-256-3650	blueshieldca.com	W0002801
	Kaiser	800-464-4000	kp.org	39046
Telehealth	Blue Shield	1-800-835-2362	teladoc.com	N/A
Dental	Cigna	800-244-6224	mycigna.com	3341881
Vision	Cigna	877-478-7557	mycigna.com	3341881
Employee Assistance Program (EAP)	IBH Claremont EAP	800-834-3773	claremonteap.com	N/A
Health Savings Account (HSA)	Health Equity (Blue Shield HDHP PPO)	866-346-5800	healthequity.com	N/A
	Kaiser (HDHP HMO)	800-464-4000	https://healthy.kaiserpermanente.org/northern-california/pages/hsa-overview	N/A
Flexible Spending Account (FSA)	Health Equity	877-924-3967	healthequity.com	N/A
Commuter Benefit Plan	Health Equity	800-733-8839	healthequity.com	N/A
Life and AD&D	Lincoln (Sourcewell)	TBD	TBD	Life: TBD AD&D: TBD
Disability	Lincoln (Sourcewell)	TBD	TBD	STD: TBD LTD: TBD
Voluntary Worksite Coverage	Unum	TBD	TBD	TBD
Leave of Absence	Leave Solutions	800-350-9105	leavesolutions.com	N/A
401(k) Investment Advice	SageView	800-814-8742 Personal Appts: 408-345-2890	sageviewadvisory.com	N/A
401(k) Enroll, change, rollover, loans & distributions	Principal	888-621-5491	principal.com	N/A

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located at the end of this guide:

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice of Grandfathered Plan Status:** Notifies you that a plan is grandfathered and does not include all Affordable Care Act (ACA) provisions
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available at the end of this guide. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- The San Francisco Foundation Health and Welfare Plan

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available on employeenavigator.com.

- Blue Shield HMO
- Blue Shield PPO
- Blue Shield HDHP PPO
- Kaiser HMO
- Kaiser HDHP HMO
- Cigna DPPO

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the San Francisco Foundation. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Medicare Part D Notice

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 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 to 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.

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…

Contact the person listed below for further information. 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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 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).

Date:	7/1/24
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

Women's Health and Cancer Rights Act

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 other 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 this plan. Contact your Human Resources Department for more information.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at [insert phone number].

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in The San Francisco Foundation's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in The San Francisco Foundation's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in The San Francisco Foundation's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for The San Francisco Foundation describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting SFF Human Resources at (415) 477-27833. A copy of our notices are also available on the web at sff.org.

Notice of Choice of Providers

The HMO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the HMO plans 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 our 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 healthcare professionals who specialize in obstetrics or gynecology, contact the carrier.

Notice of Grandfathered Plan Status

San Francisco Foundation believes the Kaiser HMO plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at hr@sff.org or (415) 477-2783. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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.

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 January 31, 2024. 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
Health Insurance Premium Payment (HIPP) Program website: 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://www.colorado.gov/pacific/hcpf/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)
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 | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660
KENTUCKY – 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://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
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
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: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – 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
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
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
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – 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)
RHODE ISLAND – Medicaid and CHIP
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 or 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/ or 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 January 31, 2024, 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

Notes


SFF
San Francisco
Foundation