2025 Employee Benefits

A GUIDE TO YOUR
BENEFITS ENROLLMENT

JAN 1, 2025 TO DEC 31, 2025

Asian
Art
Museum

Herbaceous Peony, from the Flowers of the Twelve Months: April, approx. 1670–1710, by Yun Bing (Chinese, 1670–1710). Ink and colors on silk. *Asian Art Museum, The Avery Brundage Collection*, B65D49.b. Photograph © Asian Art Museum of San Francisco.

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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 Notices section of this guide for more details.

At the Asian Art Museum Foundation, we value your contributions to our success and want to provide you with a benefits package that protects your health and enhances your financial security. We continually look for valuable benefits that support your needs, whether you are single, partnered, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your specific benefit plan booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

A list of plan contacts is included at the back of this guide.

The benefits in this summary are effective:

January 1, 2025 - December 31, 2025

Who Can You Cover?

WHO IS ELIGIBLE?

In general, “regular” (vs. “temporary”) full-time or part-time employees working 20 or more hours per week are eligible for the benefits outlined in this overview. In order to comply with the Affordable Care Act (ACA), Asian Art Museum Foundation determines your eligibility for medical coverage using the Monthly Measurement Period. **Refer to the Eligibility matrix on the next page for details of eligibility and waiting period by plan.**

You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law)
- Your domestic partner
- Your children (including your domestic partner's children):
    - Under age 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be legally partnered (married/domestic partnership) and/or living and working on their own.
    - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

ENROLLMENT PERIODS

Coverage for new full-time or part-time employees begins on the 1st of the month following 30 days of employment.

After that, Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event. **Refer to the Eligibility matrix on the next page to view waiting periods by plan.**

Notify Human Resources within 31 days if you have a qualifying life event and need to add or drop dependents outside of Open Enrollment. Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage or divorce

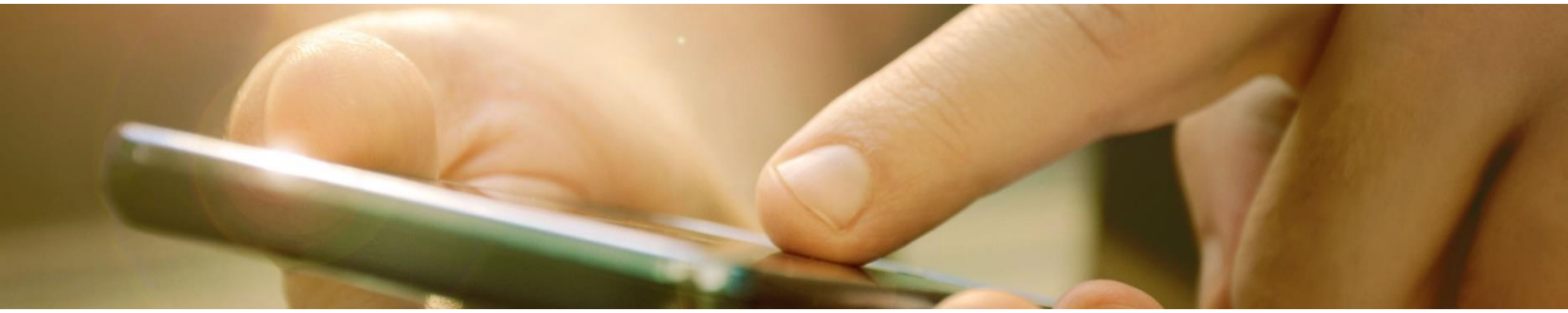
WAIVING HEALTHCARE COVERAGE

If you have coverage through another plan, you may choose to waive coverage. If you waive coverage, you may not be able to enroll in benefits until the next Open Enrollment period unless you have a qualifying life event. If waiving coverage, you must submit proof of your coverage.

TERMINATION OF COVERAGE

If your employment with Asian Art Museum Foundation ends, your health insurance coverage will continue until the last day of the month in which you terminate employment. This is also true if you continue to be employed by Asian Art Museum Foundation but no longer work the required number of hours to be benefit-eligible. You may continue benefits for a limited period of time under your federal and state COBRA rights. Coverage in life and disability plans ends on the last day of your employment, although you will be given an opportunity to convert your coverage to an individual policy.

Eligibility



Benefit Program	Who is Eligible?	When Does Participation Begin?	When Does Participation End?
Medical	Full time or part time employees working 20+ hours per week. Legal partners and children generally are covered.	First day of month following 30 days of hire date and proper election	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.
FSA	All employees who are eligible for the Medical benefit program	At the same time as Medical benefit program eligibility	Immediately upon termination of employment
Dental	Full time or part time employees working 20+ hours per week. Legal partners and children generally are covered.	First day of month following 30 days of hire date and proper election	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.
Vision	Full time or part time employees working 20+ hours per week. Legal partners and children generally are covered.	First day of month following 30 days of hire date and proper election	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.
EAP	All employees	First day of month following 30 days of hire date	At the end of the month in which coverage is dropped or employment is terminated.
Life/AD&D	Full time regular employees working 32+ hours per week.	First day of month following one year of continuous service.	Date of termination or loss of eligibility
LTD	Full time regular employees working 32+ hours per week. Legal partners and children generally are covered.	First day of month following one year of continuous service.	Date of termination or loss of eligibility

About Our Medical Plans

Asian Art Museum Foundation offers a choice between HMO and PPO medical plans. The table below highlights the similarities and differences between our medical plan options. Please contact Human Resources for additional information or if you have any questions.

	Health Maintenance Organization (HMO)	Preferred Provider Organization (PPO)
Plan Providers	Kaiser HMO Health Net HMO	Health Net PPO
Description	A restricted group of doctors and facilities that have contracted with the HMO to offer services at a discounted rate.	A combination of in- and out-of-network providers. In-network doctors and facilities have agreed to offer services at reduced, contracted fees.
Accessing Care	When you enroll, you and your eligible dependents each select a Primary Care Physician (PCP) to coordinate all your medical care within the provider's network. Kaiser does not require a PCP, but all services must be provided by Kaiser physicians at Kaiser facilities. Otherwise, you won't be covered, except in emergencies. Health Net will automatically assign you a PCP if you do not elect one when you enroll.	You can choose between in- and out-of-network benefits each time and do not need referrals or Primary Care Physician (PCP) authorization for specialists.
Restrictions	You must use the HMO's network of doctors and facilities every time you receive care.	To receive in-network benefits, you must use the provider's network of doctors and facilities.
Out-of-Pocket Costs	Services are generally paid for with copays. There are generally no deductibles.	There are annual deductibles, copays and coinsurance. If you visit doctors and hospitals within the provider network, you will typically benefit from lower costs.

WHICH PLAN IS BEST FOR YOU?

To determine which plan is best for you and your family, it is important to consider various features of each plan:

- Upfront costs: how much is taken out of your paycheck before you even access care
- Out-of-pocket costs: deductibles, coinsurance, and copays at time of service (HMOs generally have lower out-of-pocket costs)
- Access to providers:
    - Doctors, hospitals, and other providers
    - Flexibility of provider choice (including out-of-network and self-referral to specialists)
    - One-stop shop for all services (e.g., Kaiser)

Medical

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

	Kaiser HMO	Health Net HMO	Health Net PPO	
	In-Network	In-Network	In-Network	Out-Of-Network
Annual Deductible	None	None	$250 per individual, up to $750 per family (combined with out-of-network)	$500 per individual, up to $1,500 per family (combined with in-network)
Annual Out-of-Pocket Max*	$1,500 per individual, up to $3,000 per family	$1,500 per individual, up to $4,500 per family	$3,000 per individual, up to $9,000 per family	$9,000 per individual, up to $27,000 per family
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited
Primary Provider Visit	$15 copay	$15 copay	$15 copay	You pay 40% after deductible
Specialist Visit	$15 copay	$15 copay	$15 copay	You pay 40% after deductible
Preventive Services	No charge	No charge	No charge (deductible waived)	You pay 40% after deductible
Acupuncture & Chiropractic Care	Acupuncture: $15 copay Chiropractic: Not covered	Not covered	$15 copay (coverage limited to 20 visits per plan year, combined with out-of-network)	You pay 40% after deductible (coverage limited to 20 visits per plan year, combined with in-network)
Lab and X-ray	No charge	No charge	You pay 20% after deductible	You pay 40% after deductible
Inpatient Hospitalization	$250 copay per admission	$250 copay per admission	You pay 20% after deductible	You pay 40% after deductible
Outpatient Surgery	$15 copay per procedure	$250 copay	You pay 20% after deductible	You pay 40% after deductible
Urgent Care	$15 copay	$15 copay	You pay 20% after deductible	You pay 20% after deductible
Emergency Room	$50 copay (waived if admitted)	$75 copay (waived if admitted)	$100 copay + You pay 20% after deductible (copay waived if admitted)	$100 copay + You pay 20% after deductible (copay waived if admitted)

*Separate annual out-of-pocket maximums for prescription drugs apply.

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. Here are the prescription drug benefits that are included with our medical plans.

	Kaiser HMO	Health Net HMO	Health Net PPO	
	In-Network	In-Network	In-Network	Out-Of-Network
Annual Out-of-Pocket Limit	N/A	Individual: $2,000 Family: $4,000	Individual: $2,000 Family: $4,000	
Retail Pharmacy				
Generic	$10 copay	$10 copay	$10 copay	$10 copay + You pay 50% average wholesale price
Preferred Brand	$25 copay	$25 copay	$25 copay	$25 copay + You pay 50% average wholesale price
Non-preferred Brand	$25 copay (if medically necessary)	$35 copay	$35 copay	$35 copay + You pay 50% average wholesale price
Specialty (Self-Injectable)	$25 copay	Same as above	$15 copay	Not covered
Supply Limit	30 days	30 days	30 days	30 days
Mail Order Pharmacy				
Generic	$20 copay	$20 copay	$20 copay	Not covered
Preferred Brand	$50 copay	$50 copay	$50 copay	Not covered
Non-preferred Brand	$50 copay (if medically necessary)	$70 copay	$70 copay	Not covered
Supply Limit	100 days	90 days	90 days	N/A

Getting Care When You Need It Now

WHEN TO USE THE ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

WHEN YOU NEED CARE NOW

What do you do when you need care right away, but it's not an emergency?

Kaiser Permanente Plan Participants

- Call Kaiser's 24/7 NurseLine at 800-464-4000
- Find an urgent care center by visiting kp.org

Health Net Medical Plan Participants

- Call Health Net's Nurse24 at 800-893-5597
- Find an urgent care center by visiting healthnet.com

KAISER AND HEALTH NET PARTNERSHIPS

Both Kaiser and Health Net partner with vendors to help provide self-care and guided resources to be your best.

Kaiser Permanente Plan Participants

- Digital resources including Calm and Headspace Care memberships.

headspace

Calm

Health Net Medical Plan Participants

Teladoc HEALTH

- Behavioral Health Benefits (PDF)

sharecare

- healthnet.sharecare.com
  - Craving to Quit (PDF)
  - Eat Right Now (PDF)
  - Lifetstyle Coaching (PDF)

Vision

Routine vision exams can not only correct vision, but also detect more serious health conditions. We offer you a vision plan through Vision Service Plan (VSP). VSP's network is comprised of a national network of private practice optometrists. To find a network provider, visit vsp.com. VSP does not issue member ID cards, and your provider will ask for the necessary information to verify your coverage before your appointment.

	VSP Vision	
	In-Network	Out-Of-Network
Network	VSP Signature	
Examination		
Benefit	$20 copay	Reimbursed up to $50 after $20 copay
Frequency	Once every 12 months	Once every 12 months
Materials	$20 copay	Reimbursed up to plan allowance after $20 copay
Eyeglass Lenses		
Single Vision Lens	No charge after materials copay	Reimbursed up to $50
Bifocal Lens	No charge after materials copay	Reimbursed up to $75
Trifocal Lens	No charge after materials copay	Reimbursed up to $100
Frequency	Once every 12 months	Once every 12 months
Frames		
Benefit	Coverage limited to $130	Reimbursed up to $70
Frequency	Once every 24 months	Once every 24 months
Contacts (Elective)		
Benefit	Coverage limited to $130 after a maximum $60 copay	Reimbursed up to $105
Frequency	Once every 12 months (in lieu of lenses and frames)	Once every 12 months (in lieu of lenses and frames)

Dental

Regular visits to your dentist can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body, and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Asian Art Museum Foundation provides you with a comprehensive coverage through Delta Dental. Delta Dental does not issue member ID cards. When scheduling an appointment, simply identify yourself as a Delta Dental member, and the provider will ask you for the necessary information to verify your coverage.

	Delta Dental PPO	
	In-Network	Out-Of-Network*
Calendar Year Deductible	$40: Individual $120: Family	$50: Individual $150: Family
Annual Plan Maximum	$1,500 per person	$1,500 per person
Diagnostic and Preventive	No charge (coverage limited to 2 per calendar year)	No charge up to allowed amount (coverage limited to 2 per calendar year)
Basic Services		
Fillings	You pay 20% after deductible	You pay 20% after deductible
Root Canals	You pay 20% after deductible	You pay 20% after deductible
Periodontics	You pay 20% after deductible	You pay 20% after deductible
Major Services	You pay 50% after deductible	You pay 50% after deductible
Orthodontic Services		
Orthodontia	You pay 50% after deductible	You pay 50% after deductible
Lifetime Maximum	$1,500 per person	$1,500 per person
Eligibility	Dependent Children and Adults	Dependent Children and Adults

*Out-of-network providers may charge you the difference between their usual fee and the dental payment.

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through twice a month payroll deductions. The money can be used for eligible healthcare and dependent day care expenses. The main benefit of using an FSA is to reduce your taxable income, which means you have more money to spend. And reimbursements from your FSA accounts are tax-free. The catch is that you have to use the money in your account by our plan year's end. Otherwise, that money is lost, so plan carefully. The plan year for flexible spending accounts is based on the calendar year from January 1 to December 31. WEX administers this program, and **you must re-enroll in this program each year**.

IMPORTANT CONSIDERATIONS

- There's no "crossover" spending allowed between health and dependent care accounts.
- Expenses must be incurred during the plan year or the additional 2½ month grace period. You have between 01/01/25 and 03/15/26 to incur expenses for this plan year. Claims must be submitted no later than 03/31/26.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- Unused amounts will be lost at the end of the plan year, so it is very important that you plan carefully before making your election.
- FSA funds can be used for eligible expense incurred by you, your spouse, and your tax dependents only. Your spouse or tax dependent children do not have to be covered on the Asian Art Museum Foundation health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep your receipts as proof that your expenses were eligible for IRS purposes.

TAX-FREE HEALTHCARE FSA

Eligible expenses include medical, dental, and vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to $3,300* per year.

TAX-FREE DEPENDENT CARE FSA

Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to $5,000* per household for eligible dependent care expenses for the year.

- **Amounts shown are evaluated annually by the IRS, and are subject to change.*

Life and Disability Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses. Also, if you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind. Coverage for basic life, AD&D, and long-term disability insurance coverage is provided by Asian Art Museum Foundation at no cost to you.

LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. Coverage is provided by Lincoln Financial.

Basic Life Amount	Plan pays 50% of annual salary up to a maximum of $50,000
Basic AD&D Amount	Plan pays 50% of annual salary up to a maximum of $50,000

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit in UKG. It's important to know that many states, including California, require that a spouse be named as the beneficiary, unless they sign a waiver.

*Benefits reduce according to a set schedule once you reach age 65 – please refer to plan documents for additional details.

LONG-TERM DISABILITY INSURANCE

Long-Term Disability (LTD) coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security, and any benefits paid under this policy will be subject to income tax.

If you qualify, long-term disability benefits begin after short-term disability benefits end. Coverage is provided by Lincoln Financial.

Monthly Benefit Amount	Plan pays 60%
Maximum Monthly Benefit	$3,000
Benefits Begin After:	
Accident	180 days of disability
Sickness	180 days of disability
Maximum Payment Period*	SSNRA

*The age at which the disability begins may affect the duration of the benefits.

Other Programs

TRANSPORTATION AND PARKING ACCOUNT

Do you have out-of-pocket commuting expenses for public transportation or for worksite parking? If so, you can save on taxes by enrolling in our Transportation Savings Account (also known as a Section 132 plan).

A Transportation Savings Account lets you set aside money—before it's taxed—through twice a month payroll deductions. You may enroll in, change your elections, or stop participating in this program each month. Monies in this account can be used in future months or plan years. If you leave Asian Art Museum Foundation, any unused account balance will be lost. WEX administers this program.

Transit products, vanpooling, and parking services are purchased with the WEX debit card, through the "pay the provider" option on the participant portal, or by filing an online claim for the out-of-pocket expenses.

Here are the maximum amounts of money you can set aside:

Transportation	Up to $325* per month
Parking	Up to $325* per month

**Amounts shown are evaluated annually by the IRS, and are subject to change. 2025 limits shown*

EMPLOYEE ASSISTANCE PROGRAM

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through ACI Specialty Benefits can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Best of all, it's free.

Help is available 24/7, 365 days a year by telephone at 800-932-0034. Other resources are available online at aci.mylifeexpert.com. Use company code ASA-272 to access.

In-person and virtual counseling may also be available, depending on the type of help you need. The program allows you and your family/household members up to 6 face-to-face visits per year (3 sessions every 6 months).

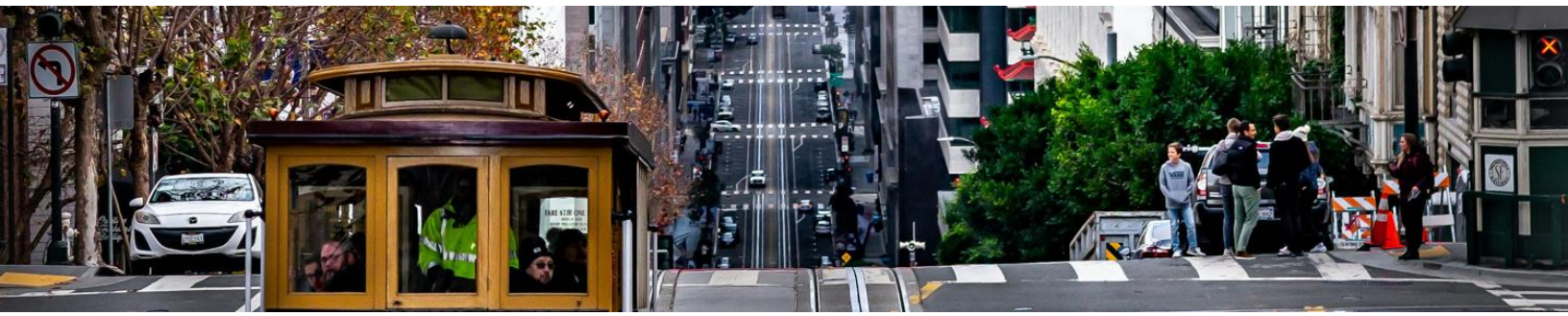
TRAVELCONNECT TRAVEL ASSISTANCE

Employees eligible for the Basic Life and AD&D plan also have free access to travel, medical, and safety-related services while traveling 100+ miles from home. Lincoln Financial has partnered with UnitedHealthcare Global to offer this valuable service. For services, call 24/7: 1-800-527-0218 or 410-453-6330 and provide them with ID number 322541. If you do not have access to a phone, you can also email assistance@uhcglobal.com.

Your resources include, but are not limited to:

- Medical emergency, evacuation, and transportation
- Dependent child transportation
- Emergency travel arrangements and funds transfer
- Assistance with lost or stolen travel documents
- Medical and dental referrals

403(b) Retirement Savings Plan



The Asian Art Museum Foundation offers two separate 403(b) retirement plans through TIAA: a voluntary Supplemental Retirement Plan and a mandatory Group Retirement Plan. Contact the Human Resources department for full details regarding participation. For complete details regarding each plan, refer to the applicable plan documents.

Contributions to the 403(b) plans can be made on a pre-tax or after-tax basis. You manage your own account, including the allocation of your contributions among available investment choices, and the designation of your beneficiary.

SUPPLEMENTAL RETIREMENT PLAN (SRA)

The Supplemental Retirement Plan is available to all employees who regularly work 20 or more hours per week. The Asian Art Museum Foundation Supplemental Retirement Annuity (SRA) can be started at any time; there is no waiting or qualifying period for this plan. Contact the Human Resources department at any time to set up an account or to change your contribution.

Each year, the elective deferral (contribution) limit is set by the IRS for employees who participate in a section 403(b) plan. There is no minimum contribution amount.

Age	Maximum Annual Contribution*
Under 50 years of age	$23,500
50+ years of age (catch-up)	$23,500 + **$7,500** = **$31,000**
60 – 63 years of age (additional catch-up)	$23,500 + $7,500 + **3,750** = **$34,750**

* The table below illustrates the maximum contribution limits for 2025. Increased catch-up limits available January 1st for those who will have attained the applicable catch-up age threshold in 2025.

Note: Mandatory contributions into the Asian Art Museum Group Retirement Annuity (GRA) are not applied to these maximum annual contributions.

GROUP RETIREMENT PLAN (GRA)

The Group Retirement Plan is a mandatory plan for all regular, active employees working 20 or more hours per week and who have one year of continuous service. Participation in this mandatory plan starts on the first day of the pay period following one year of continuous service.

Foundation Contribution	Participant Contribution
5%	2.5%

Participant contributions to the Group Retirement Plan are always 100% vested. Foundation contributions are vested based upon a graded five-year vesting schedule. Details can be found in plan documents.

NWK Group is here to help you save for a successful retirement. They can provide assistance in creating your investment strategy and answer any of your retirement planning questions. Feel free to reach out to the team for a complimentary retirement review. You may reach them at (888) 736-4015 or online here: www.nwkgroup.com/employee-resources

Cost of Coverage – Semi-Monthly (24 per Year)

Asian Art Museum Foundation pays the full cost of employee only medical coverage for all benefit-eligible employees. For full-time employees, Asian Art Museum Foundation also pays the full cost of employee-only coverage for dental, vision, basic life, AD&D, and LTD. You share in the cost of coverage for other plans and coverage levels through twice a month payroll deductions.

In general, you pay for health coverage before federal, state, and social security taxes are withheld, so you pay less in taxes. Unless your domestic partner is your tax dependent, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and their dependents will be reported as taxable income on your W-2. Please notify the HR department if your domestic partner is your tax dependent.

		30+ hours per week	20-29 hours per week
KAISER MEDICAL HMO	Total Cost	Your Cost (FT)	Your Cost (PT)
Employee Only	$474.70	$0.00	$0.00
Employee + Spouse	$1,139.28	$227.85	$759.52
Employee + Children	$830.73	$166.15	$450.97
Employee + Family	$1,447.84	$434.35	$1,068.08
HEALTH NET MEDICAL HMO	Total Cost	Your Cost (FT)	Your Cost (PT)
Employee Only	$618.17	$0.00	$0.00
Employee + Spouse	$1,483.62	$296.73	$989.08
Employee + Children	$1,081.80	$216.36	$587.26
Employee + Family	$1,885.42	$565.62	$1,390.88
HEALTH NET MEDICAL PPO	Total Cost	Your Cost (FT)	Your Cost (PT)
Employee Only	$660.39	$0.00	$0.00
Employee + Spouse	$1,584.92	$316.99	$1,056.61
Employee + Children	$1,155.67	$231.13	$627.36
Employee + Family	$2,014.17	$604.25	$1,485.86
DELTA DENTAL PPO	Total Cost	Your Cost (FT)	Your Cost (PT)
Employee Only	$30.49	$0.00	$6.10
Employee + Spouse	$59.80	$11.96	$35.41
Employee + Children	$69.97	$14.00	$45.58
Employee + Family	$98.47	$29.54	$74.08
VSP VISION	Total Cost	Your Cost (FT)	Your Cost (PT)
Employee Only	$4.83	$0.00	$0.97
Employee + Spouse	$8.28	$1.66	$4.41
Employee + Children	$8.45	$1.69	$4.59
Employee + Family	$13.62	$4.09	$9.76

Plan Contacts

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

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical	Kaiser	(800) 464-4000	kp.org	602232
	Health Net	PPO: (800) 676-6976 HMO: (800) 522-0088	healthnet.com	PPO: N8534A (EE, +SP, +FA) N8534B (EE+CH(Ren)) HMO: 68122A (EE, +SP, +FA) 68122B (EE+CH(Ren))
Dental	Delta Dental	(800) 765-6003	deltadental.com	19046
Vision	VSP	(800) 877-7195	vsp.com	30001389
Flexible Spending Accounts	WEX	(866) 451-3399	wexinc.com/login/benefits-login/	17539
Transit and Parking	WEX	(866) 451-3399	wexinc.com/login/benefits-login/	17539
Retirement	TIAA	(800) 842-2776	tiaa.org	#334684
Retirement Advisors	NWK Group	(888) 736-4015	nwkgroup.com/employee-resources	
Life and Long Term Disability	Lincoln Financial Group	(800) 423-2765, option 1	lfg.com	Life/AD&D: 000010149444 LTD: 000010149445
Employee Assistance Program	ACI	(800) 932-0034	asianart.acieap.com	N/A
Travel Assistance	Lincoln + UHC Global	(800) 527-0218 +1 (410) 453-6330	assistance@uhcglobal.com	322541
UKG	UKG		nw11.ultipro.com	
Asian Art Museum	Human Resources	(415) 581-3723 (415) 581-3721	humanresourcesdepartment@asianart.org	

Additional Resources

MOBILE APPS

Stay informed while you're on the go! Many of your benefit plans offer apps that provide personalized information about your benefits coverage and individual usage.

Visit the plan's website for app information or search the Apple Store or Google Play.

Provider	App	
KAISER PERMANENTE	GET IT ON Google Play	Download on the App Store
health net	GET IT ON Google Play	Download on the App Store
DELTA DENTAL	GET IT ON Google Play	Download on the App Store
vsp vision care	GET IT ON Google Play	Download on the App Store
ACI SPECIALTY BENEFITS An AllOne Health Company		
wex BENEFITS	GET IT ON Google Play	Download on the App Store
UKG	GET IT ON Google Play	Download on the App Store

Terms You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if understand the most common terms, explained below in plain English.

MEDICAL

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.

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.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

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. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred 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.

DENTAL

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

USUAL, CUSTOMARY AND REASONABLE (URC) – Carriers determine UCR limits by considering what the majority of providers in the same geographic area charge for a particular service. If the provider's fees are lower than UCR, the plan will pay benefits based on actual charges. If fees are higher, the plan will pay benefits based on UCR, and you will be responsible for the difference.

Important Plan Notices and Documents

CURRENT HEALTH PLAN NOTICES

Certain notices must be provided to plan participants on an annual basis and are included in the following pages of this booklet:

- 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.
- Notice of Choice of Providers
  Notifies you about the plan's requirement that you name a Primary Care Physician (PCP).
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
  Describes availability of premium assistance for Medicaid eligible dependents.
- COBRA Continuation Coverage General Notice
  Describes your right to COBRA continuation coverage, when it may become available to you and your family, and your obligations to notify the plan when you or your dependents experience a qualifying event.

MONTHLY MEASUREMENT PERIOD

In order to comply with the Affordable Care Act (ACA), Asian Art Museum Foundation uses the monthly measurement method to determine whether an employee meets this eligibility threshold. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility.

You and your dependents are eligible for the plan if you are a full-time employee. A full-time employee is generally an employee who works on average 130 hours per month, as defined by the ACA. Hours that count toward full-time status include each hour for which an employee is paid or entitled to payment for the performance of duties for the employer, and each hour for which an employee is paid or entitled to payment for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

Summary Plan Descriptions

A Summary Plan Description (SPD) is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries. The following Summary Plan descriptions is available:

- Asian Art Museum Health & Welfare Plan

If you would like a copy of the SPD, please contact Human Resources.

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Asian Art Museum Health & Welfare Plan. 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 Asian Art Museum Foundation of San Francisco 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 Asian Art Museum Foundation of San Francisco 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. Asian Art Museum Foundation of San Francisco has determined that the prescription drug coverage offered by the Asian Art Museum Health & 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 Asian Art Museum Foundation of San Francisco coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Asian Art Museum Health & Welfare Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Asian Art Museum Foundation of San Francisco prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Asian Art Museum Foundation of San Francisco 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 Asian Art Museum Foundation of San Francisco 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:	January 1, 2025
Name of Entity/Sender:	Asian Art Museum Foundation of San Francisco
Contact-Position/Office:	Human Resources Manager
Address:	200 Larkin Street, San Francisco, CA 94102
Phone Number:	(415) 581-3723

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. If you would like more information on WHCRA benefits, call your plan administrator (415) 581-3723.

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 (415) 581-3723.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Asian Art Museum Foundation of San Francisco'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 Asian Art Museum Foundation of San Francisco'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 Asian Art Museum Foundation of San Francisco'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 Asian Art Museum Health and Welfare Plan describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the plan administrator at (415) 581-3723.

Notice of Choice of Providers

The Kaiser HMO and Health Net HMO 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 plan issuer designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser at (800) 464-4000 or Health Net at (800) 522-0088.

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

You do not need prior authorization from Kaiser, Health Net, or from any other person (including a primary care provider) 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 health care professionals who specialize in obstetrics or gynecology, contact the plan issuer at the numbers listed above.

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, 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://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
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) 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/health-care-coverage/ | Phone: 1-800-657-3672
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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
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: 1-866-614-6005
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | 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
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
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 July 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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 (9.02% in 2025) of your modified adjusted household income.

COBRA Continuation Coverage General Notice

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Human Resources.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Contact Human Resources to request Plan and COBRA continuation coverage information.

Our Vision

Where experiences of Asian and Asian American art and cultures inspire and connect us all.

Our Mission

The Asian Art Museum celebrates, preserves, and promotes Asian and Asian American art and cultures for local and global audiences. We provide a dynamic forum for exchanging ideas, inviting collaboration, and fueling imagination to deepen understanding and empathy among people of all backgrounds.

Our Values

The Asian Art Museum of San Francisco strives to be respectful, engaging, inspirational, nimble and accessible.