2022 Employee Benefits Overview

WILLIAM + FLORA
Hewlett
Foundation

INSIDE THIS GUIDE

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 Annual Notices on the Source for more details.

Benefits In Focus

At The William and Flora Hewlett Foundation, we value your contributions to our shared success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you're single, married, raising a family, or thinking ahead to retirement. We're 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. The plan benefit booklets determine how all benefits are paid.

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

This guide is an overview

The benefits in this summary are effective: January 1, 2022 through December 31, 2022.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your summary plan descriptions (SPDs) located on the Source.

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

Eligibility & Enrollment

Who's Eligible for Benefits?

In general, full-time employees working at least 24 hours per week are eligible for the benefits outlined in this overview. In order to comply with the Affordable Care Act (ACA), The William and Flora Hewlett Foundation determines your eligibility for medical coverage using the Monthly Measurement Method. Refer to the Monthly Measurement Method section of this guide for additional details.

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

- Your spouse (the person who you're legally married to under state law, including a same-sex spouse.)
- Your same or opposite sex domestic partner. The Cost of Coverage section explains the tax treatment of domestic partner coverage.
- Your children (including your domestic partner's children):
    - Under age 26. They don't have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they're 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.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

Who's Not Eligible for Benefits?

Family members who aren't eligible for coverage include (but aren't limited to):

- Parents, grandparents, and siblings.
- Any dependent who's a covered employee of The William and Flora Hewlett Foundation.
- Employees who work less than 24 hours per week, temporary employees, contract employees, or employees residing outside the United States.

Enrollment Periods

Coverage for new eligible employees begins on your date of hire. New employees who don't make an election within 30 days of becoming eligible will automatically be enrolled for single coverage in the Anthem High Deductible Health Plan (HDHP). After that, Open Enrollment is the one time each year that you can make changes to your benefit elections without a qualifying life event.

Notify Human Resources within 31 days if you have a qualifying life event and need to add your dependents outside of Open Enrollment. Life events include (but aren't limited to):

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

Medical Insurance

Anthem Blue Cross HDHP

	In-network	Out-of-network [1]
Hewlett's Annual HSA Contribution	$1,750 if you elect Single coverage; $3,500 if you elect Family coverage	
Annual deductible [2]	$1,400 single $2,800 per individual, up to $3,000 per family	$4,200 single $4,200 per individual, up to $8,400 per family
Annual out-of-pocket maximum [2]	$3,000 single $3,000 per individual, up to $6,000 per family	$9,000 single $9,000 per individual, up to $18,000 per family
Primary care provider office visit	You pay 10% after deductible	You pay 30% after deductible
Specialist office visit	You pay 10% after deductible	You pay 30% after deductible
Preventive care	No charge (deductible waived)	You pay 30% after deductible
Chiropractic Care (limited to 30 visits per year)	You pay 10% after deductible	You pay 30% after deductible
Acupuncture (limited to 20 visits per year)	You pay 10% after deductible	You pay 30% after deductible
Diagnostic & Advanced lab and X-ray	You pay 10% after deductible	You pay 30% after deductible [3]
Urgent care	You pay 10% after deductible	You pay 30% after deductible
Emergency room	You pay 10% after deductible	You pay 10% after deductible
Hospitalization	You pay 10% after deductible	You pay 30% after deductible (coverage limited to $1,000 per day)
Outpatient surgery	You pay 10% after deductible	You pay 30% after deductible (coverage limited to $350 per day)
PRESCRIPTION DRUGS		
Annual deductible	Combined with medical	Combined with medical
Annual out-of-pocket maximum	Combined with medical	Combined with medical
Retail Pharmacy		
Generic (Tier 1)	Tier 1a: $5 copay Tier 1b: $15 copay	Tier 1a, Tier 1b: 30% coinsurance up to $250
Preferred Brand (Tier 2)	$40 copay after deductible	You pay 30% after deductible (up to $250 per prescription)
Non-Preferred Brand (Tier 3)	$60 copay after deductible	You pay 30% after deductible (up to $250 per prescription)
Specialty (Tier 4)	You pay 30% after deductible (up to $250 per prescription)	You pay 30% after deductible (up to $250 per prescription)
Mail Order Pharmacy		
Generic (Tier 1)	Tier 1a: $12.50 copay Tier 1b: $37.50 copay	Not covered
Preferred Brand (Tier 2)	$120 copay after deductible	Not covered
Non-Preferred Brand (Tier 3)	$180 copay after deductible	Not covered
Specialty (Tier 4)	You pay 30% after deductible (up to $250 per prescription)	Not covered
Number of days' supply	**Retail Pharmacy:** 30 days **Mail Order:** 90 days (30 days for specialty)	**Retail Pharmacy**: 30 days **Mail Order:** Not covered

1. If you use out-of-network providers, you will be responsible for "balance billing" which is the difference between what the plan will reimburse and the amount billed by the provider.
2. No one family member will pay more than the individual deductible and individual out-of-pocket maximum.
3. Daily maximums apply for out-of-network providers.

Medical Insurance

Anthem and Kaiser HMOs (In-Network Only)

	Anthem HMO	Kaiser HMO
Annual deductible	None	None
Annual out-of-pocket maximum	$1,500 per individual up to $3,000 per family	$1,500 per individual up to $3,000 per family
Primary care provider office visit	$10 copay	$15 copay
Specialist office visit	$10 copay	$15 copay
Preventive care	No charge	No charge
Chiropractic Care (limited to 20 visits per year)	$10 copay (combined with acupuncture)	$15 copay (combined with acupuncture)
Acupuncture (limited to 20 visits per year)	$10 copay (combined with chiropractic)	$15 copay (combined with chiropractic)
Diagnostic lab and X-ray	Diagnostic: No charge Advanced Imaging: $100 copay per test	Diagnostic: No charge Advanced Imaging: No charge
Urgent care	$10 copay	$15 copay (copay waived if admitted)
Emergency room	$100 copay (copay waived if admitted)	$50 copay (copay waived if admitted)
Hospitalization	No charge	$250 copay per admission
Outpatient surgery	No charge	$15 copay per procedure
PRESCRIPTION DRUGS		
Annual deductible	None	None
Annual out-of-pocket maximum	Combined with medical	Combined with medical
Retail Pharmacy		
Generic (Tier 1)	Tier 1a: $5 copay Tier 1b: $15 copay	$15 copay
Preferred Brand (Tier 2)	$30 copay after deductible	$30 copay
Non-Preferred Brand (Tier 3)	$50 copay after deductible	$30 copay (when approved through exception process)
Specialty (Tier 4)	You pay 30% (up to $250 per prescription)	$30 copay (when approved through exception process)
Mail Order Pharmacy		
Generic (Tier 1)	Tier 1a: $12.50 copay Tier 1b: $37.50 copay	$15 copay
Preferred Brand (Tier 2)	$90 copay after deductible	$30 copay
Non-Preferred Brand (Tier 3)	$150 copay after deductible	$30 copay (when approved through exception process)
Specialty (Tier 4)	You pay 30% (up to $250 per prescription)	$30 copay for a 30 day supply (when approved through exception process)
Number of days' supply	**Retail Pharmacy:** 30 days **Mail Order:** 90 days (30 days for specialty)	**Retail Pharmacy:** 100 days **Mail Order:** 100 days

Know Where to Go

ER or urgent care?

The emergency room shouldn't be your first choice unless there's a true emergency.

Consider urgent care for...

Symptoms, pain or conditions that require quick medical attention but do not require hospital care, such as:

- Earache
- Sore throat
- Rashes
- Sprains
- Broken fingers or toes
- Flu
- Fever up to 104 degrees

Go to the emergency room for...

Serious or life threatening conditions that require immediate treatment that you can get only at a hospital, such as:

- Chest pain or severe abdominal pain
- Trouble breathing
- Loss of consciousness
- Severe bleeding that can't be stopped
- Large broken bones
- Major injuries from a car crash, fall or other accident
- Fever above 104 degrees

Can't get to the doctor's office? Have your visit online!

Plan	Member Cost Share	Web
Anthem Blue Cross HDHP	**PCP and Mental Health & Substance Use:** No charge after deductible **Specialist:** 10% coinsurance after deductible	livehealthonline.com
Anthem Blue Cross HMO	**PCP and Mental Health & Substance Use:** No charge **Specialist:** $10 copay	livehealthonline.com
Kaiser HMO	No charge	kp.org/mydoctor/videovisits

Other non-emergency care options

Our medical plans offer plenty of options when you need care or advice, but it's not an emergency:

Plan	Call a nurse 24/7	Find doctor/urgent care
Anthem Blue Cross HDHP	(800) 337-4770	Log into your Anthem member portal or click here **CA plan/network:** Blue Cross PPO (Prudent Buyer) – Large Group **Outside CA plan/network:** National PPO (BlueCard PPO)
Anthem Blue Cross HMO	(800) 337-4770	Log into your Anthem member portal or click here **CA plan/network:** Blue Cross HMO (CACare) – Large Group
Kaiser HMO	(866) 454-8855	Log into your Kp.org account or click here

Dental Insurance

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.

The foundation provides you with comprehensive coverage through Delta Dental.

Delta Dental PPO Plan

	In-Network [1]	Out-of-Network [1]
Annual deductible	$40 per individual, up to $120 per family [2]	$50 per individual, up to $150 per family [2]
Annual plan maximum	$2,000 per individual [2]	$2,000 per individual [2]
Diagnostic and preventive	No charge, deductible waived (coverage limited to twice per calendar year)	No charge, deductible waived (coverage limited to twice 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 (coverage limited to every 2 years)	You pay 20% after deductible (coverage limited to every 2 years)
Major services	You pay 50% after deductible	You pay 50% after deductible
Orthodontia services		
Orthodontia	You pay 50%, deductible waived	You pay 50%, deductible waived
Dependent children	Covered	Covered
Adults	Covered	Covered
Lifetime maximum	$1,500 per individual [3]	$1,500 per individual [3]

1. Reimbursement is based on PPO contracted fees for PPO dentists, and program allowance for non-Delta Dental dentists.
2. Deductible and annual or lifetime plan maximums cross-apply in- and out-of-network.
3. Orthodontic lifetime plan maximum cross-applies in- and out-of-network.

Vision Insurance

Vision coverage helps with the cost of eyeglasses or contacts. However, 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'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and other related services. Visit the plan's website to check out these extra savings.

The foundation offers vision coverage through Vision Service Plan (VSP).

Vision Service Plan Signature PPO

	In-network	Out-of-network
Copay	**Exam:** $10 copay **Materials:** $25 copay	**Exam:** $10 copay (reimbursed up to $50) **Materials:** $25 copay
Frames	Covered up to $130 + 20% discount off amount over allowance	Reimbursed up to $70 after materials copay
Lenses	**Single Vision**: No charge after materials copay **Bifocal:** No charge after materials copay **Trifocal:** No charge after materials copay	**Single Vision:** Reimbursed up to $50 after materials copay **Bifocal:** Reimbursed up to $75 after materials copay **Trifocal:** Reimbursed up to $100 after materials copay
Contacts (elective)	Covered up to $130	Reimbursed up to $105
Frequency	**Exam:** Once every calendar year **Frames:** Once every other calendar year **Lenses**: Once every calendar year **Contacts (Elective):** Once every calendar year (in lieu of lenses and frames)	**Exam:** Once every calendar year **Frames:** Once every other calendar year **Lenses**: Once every calendar year **Contacts (Elective):** Once every calendar year (in lieu of lenses and frames)
Additional Benefit		
Computer Vision Care	This employee-only service provides supplemental vision analysis addressing the specific visual needs of computer use. The analysis is available once every 12 months.	
Copay	**Exam & Materials:** $10 copay	**Exam & Materials:** $10 copay
Frames	Covered up to $90	Reimbursed up to $70 after materials copay

Mental Wellbeing Programs

Do you ever wish your family had a back-up team to help you manage the demands of daily life? These benefit plans are 100% confidential and available to help make life a little easier when you need extra support.

Claremont Employee Assistance Program (EAP)

The EAP through Claremont provides multiple behavioral health solutions to enhance your well-being. EAP 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 completely confidential and available to any member of your immediate household.

- Unlimited free phone access 24/7
- Up to **6 short-term counseling sessions** per incident per family member per year
- Up to **10 virtual support sessions** per year including recovery groups lead by certified specialists to address a range of issues such as addiction, depression and anxiety.
- Unlimited access to helpful articles, resources, and self-assessment tools.

Contact the EAP 24/7/365	Phone: **(800) 834-3773** Web: **claremonteap.com**

Spring Health Mental Wellbeing

Spring Health is a mental health benefit that provides you with a range of resources to meet nearly any need, and help you figure out what might work best for you.

Through our partnership with Spring Health, you will receive:

- **Up to 8 therapy sessions**, at no-cost to the employee.
- **Unlimited, confidential wellness assessments.** Spring offers a sophisticated, online questionnaire that accurately and efficiently screens for common mental health conditions. The assessment takes under 5 minutes and your results are confidential.
- **Care navigation** from a licensed therapist to review your assessment results and answer any questions you might have about mental health or treatment options moving forward.
- **Provider matching where available.** Spring can help you get connected to a therapist or physician in less than a week, with appointments available in the evenings and on weekends. Spring has a diverse network of providers with different backgrounds in training, language, gender, race, and sexual orientation. Spring's approach to diversity encompasses not only who the care provider is, but also what they do best.

We encourage everyone who needs support to take advantage of this program by completing your confidential wellness assessment at the following website: **care.springhealth.com**.

Spring Health crisis support is available 24/7. Contact the CareTeam via phone at **(240) 558-5796** or via email at **careteam@springhealth.com**.

Compare Pre-Tax Health Accounts

Would you like to save on medical, dental and vision costs? Using a health account saves you money because you can pay your healthcare bills with tax-free dollars! There are different pre-tax accounts for different situations and needs. Each type of account has its own eligibility requirements and rules.

	Health Savings Account (HSA)	Healthcare Flexible Spending Account (FSA)
Medical plan enrollment	HDHP. You may not have other non-HDHP coverage	Any non HDHP
Eligible dependents	Spouse and tax dependents. Adult children must be tax dependents. Domestic partner may open a separate HSA and contribute post-tax.	Spouse, children under age 27, and tax dependents. Domestic partner must be tax dependent.
Annual Contribution from Hewlett Foundation	Single coverage: $1,750 Family coverage: $3,500	$0
Annual contribution limit	$3,650 single or $7,300 family, including Hewlett funds. Extra $1,000 allowed after age 55.	$2,850
Federal and state tax	No federal tax. CA and NJ do not exclude HSA contributions from income.	None
Funds are available	After deposit	Day 1 of plan year
Account balance earns interest	Yes, plus investment options after account balance reaches $1,000	No
Allows rollover to next plan year	Yes, unlimited	No, unused balance is forfeited after the grace period
Grace Period	N/A	2.5 months after end of plan year to spend prior year balance
If you leave Hewlett Foundation	Your account goes with you for future eligible healthcare expenses, tax-free.	You can spend your balance if you elect COBRA continuation coverage.
Administered by	Bank of America	Navia

Health Savings Account (HSA)

A Health Savings Account (HSA) is a tax-advantaged, portable (you own it!) savings account that can help you save money on taxes and even save for the future.

The foundation offers an HSA through Bank of America for employees enrolled in our Anthem High Deductible Health Plan (HDHP. The foundation and you (if you choose to) may contribute pre-tax to your HSA to save for out-of-pocket healthcare expenses. Any money that you don't spend grows year after year and can be used in the future, even after you retire. You may access your Bank of America HSA by calling **(800) 718-6710** or online at **myhealth.bankofamerica.com**.

Account Contributions

		Single HDHP Coverage	Family HDHP Coverage
Hewlett Contributes [1]		$1,750	$3,500
You Can Contribute (up to…)	+	$1,900	$3,800
Maximum Annual IRS Limit [2]	=	**$3,650**	**$7,300**
Catch Up Contributions [2]		An additional $1,000 per year at age 55+	

1. Hewlett contributions: 50% of the foundation's contribution to your HSA is made in the 2nd payroll in January if you remain employed and are enrolled in the plan as of January 15th. The other 50% is pro-rated over the remaining eleven (11) months, if you remain employed. HSA contributions for mid-year enrollees are pro-rated.
2. IRS contribution limits: Limits are set by the IRS and assume full calendar-year participation.

Using Your Money

You can use your account to pay for qualified healthcare expenses that aren't paid for by your HDHP. When possible, use your HSA debit card to pay for expenses. If you've paid out-of-pocket, you can submit a request from the Bank of America HSA portal. You can also take your HSA debit card to any bank and request a cash advance. Make sure that you keep records of your receipts and any OTC prescriptions in case the IRS requests them.

In general, your HSA can be used for the following expenses:

- Medically necessary expenses that aren't covered by your health plan including deductibles and coinsurance
- Dental care services
- Vision care services
- Prescription drugs
- Over-the-counter (OTC) medications prescribed by your doctor
- Certain medical equipment

Eligibility

You aren't eligible to open or contribute to an HSA if you're:

- Covered by a non-high deductible health plan
- Enrolled in a regular healthcare flexible spending account (you or your spouse count)
- Covered under Medicare, Medicaid or Tricare
- Can be claimed as someone else's tax dependent

Setting up your HSA

Your HSA will be automatically established with Bank of America when you first enroll in the HDHP. Please notify HR immediately if you are not eligible to open an HSA.

Non-Qualified Expenses

If you use HSA funds for non-qualified expenses before you are age 65, you will owe a 20% penalty tax PLUS income tax on the withdrawal. After age 65, if you use HSA funds for non-qualified expenses, you will owe income tax only.

Flexible Spending Accounts (FSAs)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. You must re-enroll in this program each year. Navia Benefit Solutions administers this program.

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 can set aside up to $2,850 for 2022 (may be indexed annually per the IRS), and the entire annual amount you elect is immediately available from the first day of the plan year.

Dependent care FSA

Eligible expenses may include daycare centers, in-home childcare, summer day camp, and before or after school care for your dependent children under age 13. Other individuals may qualify if they're your tax dependent and are incapable of self-care. It's important to note that you can only access funds as you contribute to the account through payroll deductions.

All caregivers must have a tax ID or Social Security number. This information needs to be included on your federal tax return. If you use the dependent care reimbursement account, the IRS won't allow you to claim a dependent care credit for reimbursed expenses. Check with 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 calendar year.

IMPORTANT CONSIDERATIONS

- There's no "crossover" spending allowed between the healthcare and dependent care accounts
- **Healthcare FSA Expenses** must be incurred between 1/1/2022 and 3/15/2023 and submitted for reimbursement no later than 3/31/2023.
- **Dependent care FSA Expenses** must be incurred between 1/1/2022 and 3/15/2023 and submitted for reimbursement no later than 3/31/2023.
- FSA funds can be used for you, your spouse, and your tax dependents only.
- If you use the dependent care FSA, the IRS will not allow you to claim a dependent care tax credit. Consult your tax advisor if you have questions about the federal tax credit.
- 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).
- If you're enrolled in a High Deductible Health Plan (HDHP) and contribute to a Health Savings Account (HSA) you can't participate in the FSA.
- 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.
- 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.

Life and Accidental Death & Dismemberment Insurance (AD&D)

Life insurance can fill a number of financial gaps for a family who experiences the death of a loved one. Consider your current and future financial needs when evaluating how much coverage you need. The most common short and long-term financial needs include:

- Medical bills and funeral expenses
- Living expenses for the surviving family (housing, food, clothing, utilities, etc.)
- Large expenses, e.g., college education, or home mortgage
- Taxes and debts that need to be settled

Make sure that you have named a beneficiary for your life insurance benefit and update it if your family or marital status changes.

Basic 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. The cost of coverage is paid in full by the foundation.

New York Life (formerly Cigna) provides coverage.

Basic Life	3 x base salary up to a maximum of $600,000
Basic AD&D	3 x base salary up to a maximum of $600,000

Taxes: A life insurance benefit of $50,000 or more is a taxable benefit. You'll see the value of the benefit included in your taxable income on your paycheck and W-2.

Benefit Reduction: Begins at age 65, refer to the plan document for details.

Voluntary Life and AD&D

Voluntary Life and AD&D Insurance allows you to purchase additional coverage to protect your family's financial security. You pay the cost of coverage.

New York Life (formerly Cigna) provides coverage.

Employee Voluntary Life and AD&D	Any multiple of $10,000 up to the lesser of five times your base salary or $1,000,000 Guarantee coverage: $100,000
Spouse/DP Voluntary Life and AD&D	Any multiple of $5,000 up to $500,000 (not to exceed 100% of employee voluntary life amount) Guarantee coverage: $20,000
Child(ren) Voluntary Life and AD&D	Any multiple of $2,000 up to $10,000 (not to exceed 100% of employee voluntary life amount) Guarantee coverage: all amounts

Evidence of Insurability: If you select a coverage amount above the "guarantee coverage" or enroll after 31 days after your become eligible, you'll need to submit an Evidence of Insurability form with additional information about your health in order for the insurance company to approve your coverage.

Benefit Reduction: Begins at age 65, refer to the plan document for details.

Disability Insurance

60% of Americans do not have a “rainy day” fund to cover three months of unanticipated financial emergencies.

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

The foundation provides STD and LTD coverage at no cost to eligible employees. New York Life (formerly Cigna) provides coverage.

Short-term disability	Long-term disability
Limited duration issues such as: • Pregnancy issues and childbirth recovery • Prolonged illness or injury • Surgery and recovery time	**Longer term issues such as:** • Debilitating illness (cancer, heart disease, etc.) • Serious injuries (accident, etc.) • Heart attack, stroke • Mental disorders

Short-term disability

Short-term disability (STD) coverage through New York Life pays a benefit if you temporarily can't work because of an injury, illness, or pregnancy. Payments may be reduced if you receive other benefits, such as sick pay, workers' compensation, Social Security, or state disability.

Weekly benefit amount	Plan pays 66.67% of covered weekly salary up to a maximum of $2,300 per week
Benefits begin	After 7 days of disability due to accident or 7 days due to sickness
Maximum payment period	25 weeks (based on the first day you are disabled, not when benefits begin)

Long-term disability

If you’re unable to work for a longer time, long-term disability (LTD) coverage through New York Life replaces part of your monthly income. 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.

Monthly benefit amount	Plan pays 66.67% of covered monthly salary up to a maximum of $10,000 per month
Benefits begin	After 180 days of disability
Maximum payment period	Social Security normal retirement age (the age at which disability begins may affect duration of benefits.)

Individual Life Insurance & Long-Term Care Resources

Concierge Life

If you're interested in purchasing additional life insurance or Long-Term Care coverage, Concierge Life can help provide the right coverage for you and your family.

Individual Life Insurance

Concierge Life provides access to life insurance providers and consultants to help you determine the appropriate level of coverage to protect yourself and your family. Once you've determined the amount of insurance you'd like to purchase, Concierge Life will assist with obtaining the best coverage at the lowest premium. This coverage is purchased as an individual policy and continues beyond your employment with The William and Flora Hewlett Foundation (assuming you continue to pay the premiums). This resource is available to employees and their family members.

Long-Term Care

Concierge Life also specializes in Long-Term Care planning to help you preserve your assets from wealth eroding factors that includes custodial care events (in-home care, nursing facilities, memory care facilities, and assisted living). Concierge Life can help employees of the foundation analyze current needs, assess what options you have to address Long-Term Care concerns, and customize individual policies unique to your household situation.

To get help from Concierge Life, contact Brian Maguire and indicate you are a foundation employee.

Phone: **(888) 466-4446**
Email: **brian.maguire@summitalliance.net**
Web: **maguireinsurance.com**

Family Support Programs

Back up Care & Additional Services

The Hewlett Foundation partners with Bright Horizons to offer the Care Advantage Program. The program provides subsidized "back-up" care, as well as access to discounted self-pay resources and tools for everyday care needs that benefit your entire family. All benefit eligible employees may participate in this program

Foundation Subsidized Benefits

Back-Up Childcare and Adult/Elder Care: Back-up care allows you to focus on work when normal care arrangements break down, or your adult/elder relative or child is mildly ill or needs temporary assistance. Care is available within a Bright Horizons center or in your own home. This program is intended to supplement, rather than replace, regular childcare/adult care arrangements.

Visit **clients.brighthorizons.com/hewlett** or call **(877) BH-CARES (877-242-2737)** to access care.

Username: **Hewlett**

Password: **care4you**

Center-based care	You pay $15 per child per day, up to a maximum of $25 per family per day [1]
In-home care	$6 per hour; 4-hour minimum [2]
Usage limits	10 back-up days per employee per calendar year

1. Bright Horizons accommodates children from 3 months up to their 13th birthday.
2. All co-payments will be collected by Bright Horizons. If you cancel **after 5 p.m. of the prior day,** you will be charged the full cost of the reservation.

Eldercare Resources

Receive support through guiding complex, time-consuming and emotional responsibility of caring for an elder with a broad spectrum of care assistance, whether it be over the phone advice or personal in-home care. Additionally, there are online tools to assist in management of appointments and medicine, communication with a Care Coach, caregiver search, and more.

Additional Family Support

Get free access to a comprehensive database of self-pay services, including caregivers, homework help, pet care, housekeeping services, and more. Discounts and preferred enrollment access for regular center-based childcare, tutoring, and test prep services are available.

Fertility HRA and Adoption Reimbursement

The foundation offers a generous lifetime benefit for qualified fertility and adoption related services administered through Navia Benefit Solutions.

Account funds can only be used while you are an eligible employee of The Hewlett Foundation. If you leave the organization, you will no longer have access to these benefits.

Refer to the separate Fertility HRA and Adoption Reimbursement plan documents for details.

International Business Travel Program

Travel can bring unpredictable circumstances for you and your family. Our business travel program is available to help you before you leave and to help if something comes up while you are away.

Travel Assistance

Our travel assistance benefits are fully covered by the foundation for eligible employees who travel for business 100 miles or more from home. This program, in partnership with International SOS, provides medical and security advice and assistance before, during, and after traveling abroad. It offers pre-trip assistance and information on things like passport/visa requirements, location-specific security and health status, foreign currency and weather.

International SOS should always be the first point of contact for assistance during your travels. They'll coordinate with the Cigna Medical Benefits for injuries and illnesses that may occur while traveling on an international business trip. International SOS is available 24 hours a day, seven days a week. For travel information and advice, access the International SOS website at internationalsos.com or call the US Call Assistance Center at **1 (215) 942-8226**.

Business Travel Accident Insurance

Business Travel Accident Insurance provides a variety of benefits to assist you while traveling on business for the foundation. Coverage includes emergency medical and evacuation assistance, rehabilitation services, and accidental death benefits. Coverage is provided by Chubb/ACE.

Travel Accident Life Benefit	2 x base salary up to a maximum of $750,000

Medical Assistance

Medical Benefits Abroad is a program designed to cover you while representing the foundation on a business trip or business sojourn when outside your home country. Cigna provides members with convenient, cashless access to a carefully selected international physician network, translation databases for brand name medications, medical terms, and phrases, as well as health and security reports for international destinations. Coverage is provided by Cigna.

Medical Maximum	$250,000
Deductible	None
Doctor Visits	No charge
Hospitalization	No charge (coverage limited to $1,000 per day)
Outpatient Surgery	No charge
Outpatient Prescription Drugs	No charge when medically necessary and for replacement of lost prescriptions that are medically necessary during an international business trip
Dental	$1,000 calendar year maximum, includes dental accident and alleviate of sudden unexpected dental pain

Commuter Program

To help you pay for additional commuting costs, you can enroll in the Transportation Savings Account (also known as a Section 132 plan).

The Commuter Program lets you set aside money—before it's taxed—through payroll deductions. Monies in this account can be used in future months or plan years, but if you leave the foundation, any unused account balance will be lost. Navia Benefit Solutions administers this program.

You can take advantage of using pre-tax dollars to pay for:

- Bus, light rail, trolley, subway, or ferry
- Vanpool
- Parking at or near work
- Parking at or near public transportation for your commute

Here are the maximum amounts of money you can set aside pre-tax*:

Parking Expense Account	Up to $280 per month [1]
Transit Expense Account	Up to $280 per month [1]
Hewlett's Contribution to your Transit Account	$280 per month

1. These amounts are evaluated annually by the IRS and are subject to change.

Enrollment and election for both the Parking and Transportation Expense Accounts (funds are held separately) will be managed directly on the Navia Benefit website. You can start, stop, or change your deductions at any time. Changes must be made in advance, by the 10th of the month, for benefits the following month. For example, if you enroll by March 10th, you will receive your April transit pass(es) at the end of March.

Any contributions in excess of the monthly IRS pre-tax limits will be deducted on a post-tax basis.

Register on the Navia website at **naviabenefits.com** to begin participating in this benefit. Once you make an election, Navia will notify us to start your payroll deduction.

Retirement Savings Plan

403(b) Retirement Plan

Our 403(b) Retirement Savings Plan through Fidelity Investments helps you save for retirement and provides tax benefits either now or later. Elective deferral contributions can be made on a pre-tax basis, lowering your current taxable income or on an after-tax basis through a Roth election.

Both accounts allow you to withdraw your money without penalty after age 59 ½. Earnings from your pre-tax account are deferred until you withdraw your money, while earnings from your Roth account are tax-free at the end of the 5-year taxable period from which the deferral is first deposited into the Roth 403(b) account.

Maximum Annual Contributions	Up to $20,500 or $27,000 if you are 50+ 1
Employer Match	Basic: 7% of your base salary for that month, plus Matching: 2 times your voluntary contribution up to a maximum of 8%

1. Annual limits are evaluated annually by the IRS and are subject to change.

All regular employees are eligible to join the 403(b) plan. You're automatically enrolled on your date of hire at 4% of your annual salary, unless you decline in writing. There's a 6-month waiting period before you become eligible for foundation contributions.

You can access your account at **fidelity.com** to review investments and manage your account and contributions. You can also contact Fidelity Investments customer service at **(800) 343-0860**.

Please refer to the Summary Plan Description for further details.

Additional Programs

These programs can lend a helping hand when you need it or just make life a little easier.

Healthcare Advocacy

Healthcare can be complicated. CareCounsel, the foundation's health advocate benefit provider, connects you with a Member Care Specialist who can help you understand and effectively navigate your health benefits. CareCounsel provides support for healthcare and insurance-related issues, including:

- Answer benefit and Open Enrollment questions
- Find in-network doctors and hospitals
- Seek second opinions
- Obtain pre-authorizations and cost estimates for procedures
- Assist with filing insurance claims and appeals
- Obtain access to the Stanford Health Library
- Get assistance with Medicare questions and the Medicare enrollment process

This benefit is available at no cost to all employees and their eligible dependents enrolled in one of the foundations health (medical, dental or vision) plans.

Phone: **(888) 227-3334** (normal business hours are M – F 6:30 am to 5:00 pm PST)
Email: **staff@carecounsel.com**

Pet Insurance

Voluntary Pet Insurance, offered by Nationwide Insurance, reimburses participants for routine pet care, accidents, and injuries. Coverage is available for dogs, cats, avian and exotic pets. Please note pre-existing conditions for pets are not covered. This coverage may be elected or cancelled at any time during the year. If you elect this coverage, premiums will be billed to your home or you may set up ACH payments directly with Nationwide. You will be responsible for the full cost of this benefit but will receive discounted pricing if enrolling through Hewlett.

Enroll online at **petinsurance.com/the-william-and-flora-hewlett-foundation**

Contact Nationwide at **PetsNationwide.com** (enter company name: The William and Flora Hewlett Foundation) or by calling **(877) 738-7874**.

TicketsAtWork

TicketsatWork is a corporate benefits program that provides employees with access to discounted packages (not always available to the general public). You can find events with discounts from 20% – 60% for travel and entertainment – preferred seating and tickets to top attractions, theme parks, shows, sporting events, movie tickets, hotels and more. To access discounts, sign-up at: **ticketsatwork.com/tickets/account.php?sub=enroll**. Use company code: "WFHF2017"

Time Off

Flex Leave

The William and Flora Hewlett Foundation provides combined paid leave for vacation or sick leave based upon your work schedule and tenure at the foundation. Accrual rates follow this schedule:

- Year One: 160 hours
- Year Two through Eight: 200 hours
- Year Nine on: 240 hours

The maximum accrual is 320 hours. You will stop earning the monthly Flex Leave accrual upon reaching this maximum. Unused Flex Leave balances will roll over to the next year up to the maximum allowed.

Paid Holidays

The foundation provides 11 paid holidays per year for all full-time, benefits-eligible employees. Additional holidays may be designated at the discretion of the foundation.

New Year's Day	January 3
Martin Luther King, Jr. Day	January 17
President's Day	February 21
Memorial Day	May 30
Juneteenth	June 20
Independence Day	July 4
Labor Day	September 5
Federal Election Day	November 1
Thanksgiving	November 24
Day after Thanksgiving	November 25
Day Before Christmas Day	December 23
Christmas Day	December 26
Year-End Holiday Closure	December 27 - 30

Cost of Coverage

The William and Flora Hewlett Foundation pays for the full cost of coverage for basic Life, AD&D, STD, and LTD coverage. You share in the cost of coverage for other plans and coverage levels.

In general, you pay for health coverage before federal, state, and social security taxes are withheld, so you pay less in taxes. 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, Hewlett's 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 HR if your domestic partner is your tax dependent.

	Earnings Under $75,000	Earnings Between $75,000 - $150,000	Earnings Between $150,000 - $225,000	Earnings Greater Than $225,000
Anthem	10%	12%	14%	16%
Kaiser	12%	14%	16%	18%
Delta Dental	15%	15%	15%	15%
VSP Vision	15%	15%	15%	15%

Voluntary Life and AD&D

Your cost for employee coverage will depend on your age and how much coverage you buy. The cost increases for a higher age and higher benefit amount. The cost of spouse coverage is based on your age and amount of spouse coverage. The cost of child coverage is based on the policy amount selected and covers all children. These rates will be calculated for you when you enroll online.

For Assistance

Get help with your benefits however you feel most comfortable. You have many different ways to get answers to your questions and assistance with coverage and claims issues. Use the resources on the following pages freely!

Get to know your benefits portal

MyBenefits.Life gives you 24/7 access to general benefits information and benefit-related documents and forms anytime, anywhere. Log on from your computer, tablet, or smartphone.

hewlett.mybenefits.life
Enter your guest key: Hewlett

Your professional Health Advocate

The foundation offers you confidential access to Health Advocates with CareCounsel who can help you with resolve healthcare and insurance-related issues

staff@carecounsel.com
(888) 227-3334
6:30 am - 5:00 pm Mon-Fri PT

Plan Contacts

Provider / Plan type	Phone	Web / Email	Policy / Group #
Anthem Medical HDHP and HMO	(800) 888-8288	anthem.com/ca	282081
Kaiser Medical HMO	(800) 464-4000	kp.org	2064
Delta Dental PPO	(888) 335-8227	deltadentalins.com	19089
VSP Vision	(800) 877-7195	vsp.com	12199326
Claremont Employee Assistance Program	(800) 834-3773	claremonteap.com	06302A
Spring Health	(240) 558-5796	Web: care.springhealth.com Email: careteam@springhealth.com	14673
Bank of America Health Savings Account	(800) 718-6710	myhealth.bankofamerica.com	N/A
Navia Flexible Spending, Commuter and Healthcare Reimbursement Accounts	(425) 452-3500	naviabenefits.com	N/A
New York Life (formerly Cigna) Life/AD&D and Disability Insurance	(800) 842-4462	newyorklife.com	Life/ADD:SGM-603670 Disability:SGD-603614
Concierge Life Individual Life Insurance	(888) 466-4446	Web: maguireinsurance.com Email: brian.maguire@summitalliance.net	N/A
Bright Horizons Backup Care	(877) 242-2737	clients.brighthorizons.com/hewlett	N/A
Nationwide Pet Insurance	(877) 738-7874	PetsNationwide.com	N/A
Cigna Medical Benefits Abroad	(800) 243-1348	cignaenvoy.com	11BYCA000267
International SOS Travel Assistance Program	(215) 942-8226	internationalsos.com	ADD-N04252019
Chubb/ACE Business Travel Accident	(800) 336-0627	chubb.com	60882
Fidelity Investments 403(b) Plan	(800) 343-0860	fidelity.com	N/A
Care Counsel Health Care Advocacy	(888) 227-3334	Web: carecounsel.com Email: staff@carecounsel.com	N/A

Words You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if you understand the most common terms.

Medical Terms

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 like 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 (Exclusive Provider Organization), 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 Terms

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 Terms

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.

Important Plan Notices & Documents

Monthly Measurement Period

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 Affordable Care Act (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.
ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. The William and Flora Hewlett Foundation uses the monthly measurement method to determine whether an employee meets this eligibility threshold

Current Health Plan Notices

Notices must be provided to plan participants on an annual basis, and are posted on the Benefits Center and include:

- **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.
- **Nondiscrimination and Accessibility Requirements Notice**
  Describes an organization's compliance with Federal non-discrimination laws along with communication and language assistance services.

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 description is available on the Benefits Center:

- **The William and Flora Hewlett Foundation Employee Health and Welfare Benefit Plan**

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. The following SBCs are available the Benefits Center.

- **Anthem HDHP**
- **Anthem HMO**
- **Kaiser HMO**

Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact HR at **(650) 234-4716**.

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.