

NOTICE TO CURRENT OR FORMER EMPLOYEE

Current or former employee:

As you are aware, in 2025 you were enrolled in the following medical, dental, and/or vision insurance plans through **EMPLOYER**:

NAME OF PLAN(S) (for example, **MEDICAL PLAN NAME** and/or **DENTAL PLAN NAME**).

One or more of these plans is a “self-funded” insurance plan. **EMPLOYER** was required to make health care expenditures on your behalf in the amount of \$3.85 per hour in 2025, pursuant to San Francisco’s Health Care Security Ordinance (HCSO). In order to comply with the HCSO, **EMPLOYER** calculated the average expenditure of this plan(s) to be **\$X.XX** per hour. These calculations were done in accordance with the HCSO Rules and guidance from San Francisco’s Office of Labor Standards Enforcement (OLSE).

Because the calculated expenditure under the plan(s) you were enrolled in fell short of the required \$3.85 per hour, **EMPLOYER** made a “top-off” payment on your behalf in the amount of **\$XXX** on or before March 2, 2026 [This payment was deposited into your Health Savings Account OR This payment was made to the San Francisco City Option program OR This payment was made in the following irrevocable way...].

[If City Option]: You can read more about the City Option program at <http://sfcityoption.org>. If you are enrolled in medical insurance, you can still be eligible for the Medical Reimbursement Account (MRA) program, and you can use **EMPLOYER’S** payment towards certain out-of-pocket medical expenses, including insurance premiums. **You will need to take steps to activate your City Option account, including registering your account.** More information about SF City Option, or for assistance with activating your account, please visit <http://sfcityoption.org> or call (415) 615-5720. [If another type of irrevocable expenditure, explain how the employee can access the funds and provide contact info for the administrator].

Please be aware that your colleagues may have received a top-off of a different amount, or no top-off payment at all. An employer’s HCSO compliance mechanism may vary by employee, based on factors such as: health plan enrollment (type of plan and # of dependents), dates of employment, number of hours worked in San Francisco, and other health care expenditures made during the year (such as dental insurance, HSA contributions, etc).

If you have any questions about this letter, your insurance plan, or the amount of the top-off payment, please contact **NAME** at **PHONE** or **EMAIL**.

For general questions about your rights under the Health Care Security Ordinance, please visit the Office of Labor Standards Enforcement (OLSE) website at <https://www.sf.gov/information/health-care-security-ordinance>.

Sincerely,

NAME
TITLE