

1. Overview & FAQs

Thank you for participating in CNJG's 2020 Foundation Benefits Survey! Time and again, members tell us that the *New Jersey Foundation Benefits & Salary Summary Report* is one of the most important and effective tools for our field--and your participation in this survey is essential to producing this important benchmarking resource.

As a survey participant you will be provided with a summary of the results. Survey results will be presented in aggregate to protect the confidentiality of data submitted from individual organizations.

Below is a Q&A to help you get started. If you have any questions please contact Craig Weinrich at craigweinrich@cnjg.org or 609.341.2022 x4215.

What is the New Jersey Foundation Benefits & Salary Summary Report?

Developed exclusively for CNJG members, the *New Jersey Foundation Benefits & Salary Summary Report* presents comprehensive benefits data specific to New Jersey's grantmaking community, alongside data from the Council on Foundations' annual salary survey. The last report, produced in 2017, can be found [on our website](#).

Given increased scrutiny in the areas of compensation and benefits, the need to benchmark this information within the field has become even more important. The *2020 New Jersey Foundation Benefits & Salary Summary Report* will make available critical information needed to determine fair compensation and benefits in the state across multiple organizational levels.

Who is eligible to participate in this survey?

To be eligible to participate in the survey, your organization must have at least one PAID (full-time or part-time) employee. The beginning of the survey will help respondents determine if they are eligible to participate. **Even if you are NOT eligible to participate, please complete the first four questions of the survey.** You will then be directed to the last page of the survey where you will be asked to submit your data.

When does the survey need to be completed?

The deadline for submitting completed surveys is **Friday, July 31, 2020.**

I'm not the right person to complete this survey, can I email it to someone else to complete?

You may forward the email that contains the survey link to someone else. The recipient will be able to click on the survey link to access the survey.

How do I enter my information to the survey?

The survey has been developed using an online tool so that you may enter all of your data online. The prompts at the bottom of each page guide you as you enter your information.

For which year/time period should I provide compensation and benefits data?

The *2020 New Jersey Foundation Benefits & Salary Summary Report* will be based on benefits and compensation data for the 2020 calendar year. Please complete the survey questions by indicating the benefits that your organization is currently offering to employees in 2020.

Why are some of the survey questions redundant?

Every effort has been made to reduce the redundancy of questions, however, you may notice some questions, though similar, ask slightly different information.

Help! The way that this question is structured is difficult (or impossible) for me to answer.

We understand organizations provide different kinds of benefits and have developed novel benefit packages. And, often, benefit packages differ within an organization. Please complete the survey questions by indicating the benefits that are offered to the majority of employees in your organization, and please use the comment boxes after some of the questions and at the end of the survey to further explain/clarify your responses. Please also note that, while many questions are required, some questions in the survey are optional and can be skipped.

How long will the survey take to complete?

If you answer every single question, the survey tool estimates it will take 60+ minutes. Depending on your answers, however, some questions will be skipped reducing that estimate. We understand this takes a long time to input, but the data and the report is one of the most valuable benefits of membership, and will help benchmark your benefits and salaries in the coming years.

Before I complete the survey, can I see all of the questions, so I know what data to collect?

Yes! CNJG posted the entire survey on our website, so you can preview it in order to know what data you need to collect. We highly recommend looking through the whole survey first, so you know what we are asking to make answering the questions easier and less time-consuming.

Once I've started the survey, can I save it and complete it another time?

You may leave the survey at any time by clicking on "Exit this survey" on the upper right hand corner of the page.

Note: if you have just entered a page of data, proceed to the next page before you exit otherwise the data just entered for the current page will not be saved. To reopen the survey, click on the link in the survey email that was sent to you.

Once I've completed the survey, how do I submit my input?

To submit your input, go to the last page of the survey and click on "Submit Survey." Your input will automatically be submitted.

I clicked on "Submit Survey," but I wasn't finished completing the survey - what should I do?

To make changes in a survey that has already been submitted, please contact Craig Weinrich at craigweinrich@cnjg.org or 609.341.2022 x4215. It will be possible for you to make changes to your survey input until the survey is officially closed on Friday, July 31, 2020.

What topics will be covered?

Following are the topics that will be covered in the survey:

- Survey Eligibility
- Organization Information
- Employment
- Leave Benefits
- Insurance Benefits
- Retirement
- Retiree Benefits
- Other Benefits
- Benefits Cost

Who do I contact if I have questions?

Please contact Craig Weinrich, CNJG's Director of Member Services, at craigweinrich@cnjg.org or 609.341.2022 x4215.

2. Survey Eligibility

* 1. What is the name of your organization?

* 2. Where is your organization's main office located?

City/Town

State/Province

* 3. Please provide the following information for the person completing this survey:

Name:

Title:

Email Address:

Phone Number:

* 4. To be eligible to participate in this survey, your organization must have at least one PAID (full-time or part-time) employee. Please indicate below if you are eligible to participate in this survey.

- My organization has at least one paid, full-time or part-time employee.
- My organization does NOT have any paid staff and, therefore, I am unable to participate in this survey.

3. Organization Information

* 5. What type of grantmaker is your organization?

- Charitable Trust
- Community Foundation
- Corporate Foundation
- Corporate Giving Program
- Family Foundation
- Federated Fund (ie. United Ways)
- Government Grantmaker
- Grantmaking Public Charity
- Operating Foundation
- Private Foundation
- Public Foundation
- Other (please specify)

* 6. To which asset group does your organization belong?

- \$500 Million or more
- \$250 to \$499.9 Million
- \$100 to \$249.9 Million
- \$50 to \$99.9 Million
- \$25 to \$49.9 Million
- \$10 to \$24.9 Million
- Less than \$10 Million
- No Endowment/Funded Annually

* 7. Approximately how much does your organization award in grants each year? (Please enter a whole, positive number. Decimals, percentages, and non-numeric characters will not be accepted.)

* 8. To which Philanthropy Serving Organization(s) does your organization belong? Check all that apply.

- Council of New Jersey Grantmakers
- Philanthropy Delaware
- Philanthropy Network Greater Philadelphia
- Philanthropy New York
- Council on Foundations
- Exponent Philanthropy
- National Center for Family Philanthropy
- None
- Other (please specify)

4. Board Information

9. How many Board members does your organization have? (if you are a corporate giving programs, you may skip this question)

10. Please indicate how many of your board members identify as the following:

Female

Male

Gender nonconforming

Other

11. How many of your Board members identify as the following? *(Please count board members in all applicable categories. For example, a board member who identifies as African-American and Latinx should be counted in both categories)*

Asian/Asian-American

Black/African-American

Hispanic/Latinx

Middle Eastern/Arab-
American

Native American/Alaska
Native

Native Hawaiian/Pacific
Islander

White

Other

Don't Know

12. How many of your Board members identify as the following:

LGBTQIA+

Persons with Disabilities

5. Employment

* 13. How many people are currently employed (both full-time and part-time) at your organization?

NOTE: Respondents affiliated with Corporate Foundations or Corporate Giving Programs should note the number of people employed in the department, as opposed to the organization as a whole.

Number of total employees

* 14. How many are employed full-time?

NOTE: Respondents affiliated with Corporate Foundations or Corporate Giving Programs should note the number of full-time employees in the department, as opposed to the organization as a whole.

Number of full-time employees:

* 15. How many are employed part-time?

NOTE: Respondents affiliated with Corporate Foundations or Corporate Giving Programs should note the number of part-time employees in the department, as opposed to the organization as a whole.

Number of part-time employees:

* 16. How does your organization define part-time employees?

- Employees who work less than 20 hours per week
- Employees who work less than 25 hours per week
- Employees who work less than 30 hours per week
- Employees who work less than 35 hours per week
- Employees who work less than 37.5 hours per week
- Employees who work less than 40 hours per week
- My organization does not have part-time employees.
- Other (please specify)

* 17. Is the CEO/Director/Administrator of the organization employed on a part-time basis?

- Yes
- No

18. Please indicate how many employees (both part-time and full-time) identify as the following:

Female

Male

Gender nonconforming

Other

19. How many employees (both part-time and full-time) identify as the following? *(Please count employees in all applicable categories. For example, an employee who identifies as African-American and Latinx should be counted in both categories)*

Asian/Asian-American

Black/African-American

Hispanic/Latinx

Middle Eastern/Arab-American

Native American/Alaska Native

Native Hawaiian/Pacific Islander

White

Other

Don't Know

20. How many employees (both part-time and full-time) identify as the following:

LGBTQIA+

Persons with Disabilities

* 21. Does your organization have any consultants on staff or on retainer?

Yes

No

6. Employment - consultants

* 22. Does your organization provide the consultants that it engages with benefits?

- Yes, consultants are eligible to receive the same benefits that organizational employees receive.
- No, consultants are not eligible to receive benefits from the organization.
- Somewhat, consultants are eligible to receive the following benefits:

7. Leave Benefits

This section will review the types of time off that your organization provides to employees. Please complete these questions by indicating the benefits that are offered to the majority of employees in your organization, and please feel free to use the comment boxes after some of the questions to further explain/clarify your responses.

* 23. Consolidated Leave (also known as PTO/Paid Time Off/Time Bank) is a type of leave plan that provides employees with a bank of paid time-off hours/days, which can be used in place of or in addition to paid vacation, sick leave, personal days, and/or holidays.

Does your organization provide paid consolidated leave (also known as PTO/Paid Time Off/Time Bank)?

Yes

No

8. Leave Benefits - Employees

* 24. Does the number of paid consolidated leave days granted to an employee differ depending on the employee's years of service with the organization?

Yes

No

* 25. Approximately how many paid consolidated leave days does your organization provide employees?

<1 year of service

1-2 years service

3-4 years service

5-9 years service

10-14 years service

15-19 years service

20 or more years service

* 26. How many unused consolidated leave days can employees carry over from one year to the next?

NOTE: If employees are NOT able to carry over unused consolidated leave from one year to the next, please put a "0" in the space provided.

Number of unused
consolidated leave days
that can be carried over
from one year to the next

27. Do you have more to add? Need to clarify a response? Please use the space below to provide any additional comments/clarifications/explanations regarding consolidated leave days.

9. Leave Benefits - Paid Vacation

* 28. Does your organization offer paid vacation days (separate from, or in addition to, consolidated leave)?

Yes

No

10. Leave Benefits - Paid Vacation Details

* 29. Does the number of paid vacation days granted to an employee differ depending on the employee's years of service with the organization?

Yes

No

* 30. Approximately how many paid vacation days does your organization provide employees?

<1 year of service

1-2 years service

3-4 years service

5-9 years service

10-14 years service

15-19 years service

20 or more years service

* 31. How many unused vacation days can employees carry over from one year to the next?

NOTE: If employees are NOT able to carry over unused vacation days from one year to the next, please put a "0" in the space provided.

Number of unused
vacation days that can be
carried over

32. Do you have more to add? Need to clarify a response? Please use the space below to provide any additional comments/clarifications/explanations regarding vacation days.

11. Leave Benefits - Paid Sick Days

* 33. Does your organization offer paid sick days (separate from, or in addition to, consolidated leave)?

Yes

No

12. Leave Benefits - Paid Sick Days Details

* 34. Does the number of paid sick days granted to an employee differ depending on the employee's years of service with the organization?

Yes

No

* 35. Approximately how many paid sick days off does your organization provide your employees?

<1 year of service

1-2 years service

3-4 years service

5-9 years service

10-14 years service

15-19 years service

20 or more years service

* 36. How many unused sick days are employees allowed to carry over from one year to the next?

NOTE: If employees are NOT able to carry over unused sick days from one year to the next, please put a "0" in the space provided.

Number of unused sick days that can be carried over

37. Do you have more to add? Need to clarify a response? Please use the space below to provide any additional comments/clarifications/explanations regarding sick days.

13. Leave Benefits - Paid Personal Days

* 38. Does your organization offer paid personal days (separate from, or in addition to, consolidated leave)?

Yes

No

14. Leave Benefits - Paid Personal Days Details

* 39. Does the number of paid personal days granted to an employee differ depending on the employee's years of service with the organization?

Yes

No

* 40. Approximately how many paid personal days off does your organization provide your employees?

<1 year of service

1-2 years service

3-4 years service

5-9 years service

10-14 years service

15-19 years service

20 or more years service

* 41. How many unused personal days are employees allowed to carry over from one year to the next?

NOTE: If employees are NOT able to carry over unused personal days from one year to the next, please put a "0" in the space provided.

Number of unused
personal days that can be
carried over

42. Do you have more to add? Need to clarify a response? Please use the space below to provide any additional comments/clarifications/explanations regarding personal days.

15. Leave Benefits - Paid Holidays

* 43. Does your organization offer paid holidays (separate from, or in addition to, consolidated leave)?

Yes

No

16. Leave Benefits - Paid Holidays Details

* 44. How many paid holidays does your organization offer?

Number of paid holidays
provided by your
organization.

* 45. What paid holidays are typically recognized?

- New Year's Day
- Martin Luther King Day
- Lincoln's Birthday
- President's Day
- Washington's Birthday
- Good Friday
- Easter Monday
- Passover
- Memorial Day
- First day of Ramadan
- Fourth of July
- Eid Al-Fitr
- Labor Day
- Rosh Hashanah
- Yom Kippur
- Eid Al-Adha
- Columbus Day
- Election Day
- Veteran's Day
- Day before Thanksgiving
- Thanksgiving
- Day after Thanksgiving
- Hanukkah (First Day Only)
- Hanukkah (All Days)
- Christmas Eve
- Christmas Day
- Day after Christmas
- New Year's Eve
- Other (please specify)

* 46. Is your organization closed the week between Christmas and New Year's Day?

Yes

No

* 47. Does your organization provide one or more floating holidays, to be used at the employee's discretion or to be selected from a pre-determined list?

Yes

No

Provide additional explanation if needed.

48. Do you have more to add? Need to clarify a response? Please use the space below to provide any additional comments/clarifications/explanations regarding holidays.

17. Leave Benefits - Summer Hours

* 49. Does your organization offer summer hours?

Yes

No

18. Leave Benefits - Summer Hours Details

* 50. Please describe your organization's summer hours program.

- Close every Friday
- Close early every Friday
- Close every other Friday
- Flextime
- Compressed work week (4 ten-hour days)
- Other (please specify)

19. Leave Benefits - Parental Leave

* 51. Does your organization offer family/parental leave (i.e. maternity leave, paternity leave, adoption leave, etc.) separate from, or in addition to, all the aforementioned types of leave and/or short-term disability and Family Medical Leave?

Yes

No

20. Leave Benefits - Parental Leave Details

* 52. How many family/parental leave days are awarded to employees, separate from, or in addition to, all the aforementioned types of leave and/or short-term disability and Family Medical Leave?

Number of PAID

family/parental leave days
available

Number of UNPAID

family/parental leave days
available

* 53. For what reason(s) can employees take parental/family leave? Check all that apply.

- For the birth of a child
- For the adoption of a child
- To care for a sick family member
- Other (please specify)

54. With regard to the birth and/or adoption of a child, who is eligible to take parental/family leave? Check all that apply.

- Mother
- Father
- Domestic Partner
- Other (please specify)

55. Do you have more to add? Need to clarify a response? Please use the space below to provide any additional comments/clarifications/explanations regarding your organization's policy for parental leave that is separate from, or in addition to, all the aforementioned types of leave and/or short-term disability and Family Medical Leave.

21. Leave Benefits - Bereavement Leave

* 56. Does your organization provide bereavement leave (separate from, or in addition to, all the aforementioned types of leave)?

Yes

No

22. Leave Benefits - Bereavement Leave Details

* 57. How many bereavement leave days are awarded to employees, separate from, or in addition to, all the aforementioned types of leave?

Number of PAID
bereavement leave days
available

Number of UNPAID
bereavement leave days
available

58. Do you have more to add? Need to clarify a response? Please use the space below to provide any additional comments/clarifications/explanations regarding your organization's policy for bereavement leave.

23. Leave Benefits - Jury Duty

* 59. Does your organization provide leave for jury duty (separate from, or in addition to, consolidated leave)?

Yes

No

24. Leave Benefits - Jury Duty Details

* 60. How many days are given to employees, separate from, or in addition to, all the aforementioned types of leave, to serve jury duty?

Number of PAID days
available for jury duty

Number of UNPAID days
available for jury duty

61. Do you have more to add? Need to clarify a response? Please use the space below to provide any additional comments/clarifications/explanations regarding your organization's policy for jury duty leave.

25. Leave Benefits - Volunteer Time

* 62. Does your organization provide leave for volunteering (separate from, or in addition to, consolidated leave)?

Yes

No

26. Leave Benefits - Volunteer Time Details

* 63. How many days are given to employees, separate from, or in addition to, all the aforementioned types of leave, to volunteer?

Number of PAID days
available for volunteering

Number of UNPAID days
available for volunteering

64. Do you have more to add? Need to clarify a response? Please use the space below to provide any additional comments/clarifications/explanations regarding your organization's policy for leave to volunteer.

27. Leave Benefits - Compensation for Unused Time

* 65. Can employees trade unused leave for compensation at the end of the year?

Yes

No

If yes, please indicate which type of leave can be traded in for compensation, the criteria for trading in for compensation, and the maximum amount allowed for compensation (in either days or dollars).

* 66. When an employee leaves the organization, either voluntarily or terminated, does your organization pay for unused PTO and/or sick time?

Yes

No

If yes, please indicate which type of leave can be traded in for compensation, the criteria for trading in for compensation, and the maximum amount allowed for compensation (in either days or dollars).

67. Does your organization offer any other types of leave not previously addressed in this section? If so, please use the space below to describe.

68. Do you have more to add? Need to clarify a response? Please use the space below to provide any additional comments/clarifications/explanations regarding leave benefits.

28. Insurance Benefits

This section will review the types of insurance benefits that your organization provides to employees and other individuals associated with your organization. Please complete these questions by indicating the benefits that are offered to the majority of employees in your organization, and please feel free to use the comment boxes after some of the questions to further explain/clarify your responses.

- * 69. Please indicate what types of insurance are available to individuals associated with your organization. Check all that apply for each category of individual.

NOTE: Insurance options available to retired employees and trustees will be addressed later in the survey.

	Employees	Employees' Spouse/Dependent	Employees' Domestic Partner	Trustees	Trustees' Spouse/Dependent/Domestic Partner
Medical - Traditional Indemnity Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical - Preferred Provider Organization (PPO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical - Health Management Organization (HMO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical - Point of Service (POS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical - Health Reimbursement Account (HRA, not flex spending)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical - Exclusive Provider Organization (EPO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical - Compensation in lieu of medical insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical - Reimbursement of medical expenses directly to individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental (part of medical plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental (separate from medical plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Plan (part of medical plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Plan (separate from medical plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Employees	Employees' Spouse/Dependent	Employees' Domestic Partner	Trustees	Trustees' Spouse/Dependent/Domestic Partner
Vision (part of medical plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision (separate from medical plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short-term Disability (state plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short-term Disability (private plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long-term Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Leave Insurance (state plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Leave Insurance (private plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basic Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supplemental Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long-term Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employer-Paid Flexible Spending Account	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accidental Death and Dismemberment (AD&D) Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
None (My organization does not offer any of the insurance plans listed above.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

* 70. If your healthcare plan uses this structure, please indicate which Tier the plan falls into.

- Bronze (these plans cover approximately 60% of healthcare costs)
- Silver (these plans cover approximately 70% of healthcare costs)
- Gold (these plans cover approximately 80% of healthcare costs)
- Platinum (these plans cover approximately 90% of healthcare costs)
- I do not know
- Our plan does not use this structure

* 71. Pursuant to the Affordable Care Act, has your organization changed the insurance plan(s) that it offers?

- Yes
- No

If you answered "Yes" to this question, please use the space below to indicate what changes have been implemented as a result of the Affordable Care Act.

72. For MEDICAL INSURANCE ONLY, when are new employees eligible to receive medical insurance from your organization?

- Start date
- First day of the month, following start date
- after one month
- after 60 days
- after 90 days
- Other (please specify)

29. Insurance Benefits - Percentage Paid for Employee

73. Please note approximately what PERCENT of the premium is paid by the organization for EMPLOYEES for the plans that are offered by your organization.

***NOTE:** If your organization does not offer the plan, please leave the corresponding field blank. If your organization provides the plan, but does not pay any of the premium, please put a "0" in the corresponding field. If your organization provides the plan, but there is another payment arrangement (such as a set dollar amount), please leave the corresponding field blank and note the arrangement in the following question.*

Medical - Traditional
Indemnity Plan

Medical - Preferred
Provider Organization
(PPO)

Medical - Health
Management Organization
(HMO)

Medical - Point of Service
(POS)

Medical - Health
Reimbursement Account
(HRA, not flex spending)

Medical - Exclusive
Provider Organization
(EPO)

Dental (separate from
medical plan)

Prescription Plan (separate
from medical plan)

Vision (separate from
medical plan)

Short-term Disability (state
plan)

Short-term Disability
(private plan)

Long-term Disability

Family Leave Insurance
(state plan)

Family Leave Insurance
(private plan)

Basic Life

Supplemental Life

Long-term Care

Employer-Paid Flexible
Spending Account (FSA)

Worker's Compensation

Accidental Death and
Dismemberment (AD&D)
Insurance

Travel Insurance

74. Please use this space to note if you have alternate payment arrangements for plans offered to employees. For example, note here if your organization pays a set dollar amount towards health insurance, in lieu of a percent of the premium.

30. Insurance Benefits - Percentage Paid for Spouse

* 75. Does your organization pay a different percent of insurance premiums for EMPLOYEES' SPOUSES/DEPENDENTS/DOMESTIC PARTNERS than it pays for employees?

- Yes
- No
- My organization does not provide any of the aforementioned insurance benefits for EMPLOYEES' SPOUSES/DEPENDENTS/DOMESTIC PARTNERS.

31. Insurance Benefits - % Paid for Spouse Details

76. Please note approximately what PERCENT of the premium is paid by the organization for EMPLOYEES' SPOUSES/DEPENDENTS/DOMESTIC PARTNERS for the plans that are offered by your organization.

NOTE: If your organization does not offer the plan, please leave the corresponding field blank. If your organization provides the plan, but does not pay any of the premium, please put a "0" in the corresponding field. If your organization provides the plan, but there is another payment arrangement (such as a set dollar amount), please leave the corresponding field blank and note the arrangement in the following question.

Medical - Traditional Indemnity Plan	<input type="text"/>
Medical - Preferred Provider Organization (PPO)	<input type="text"/>
Medical - Health Management Organization (HMO)	<input type="text"/>
Medical - Point of Service (POS)	<input type="text"/>
Medical - Health Reimbursement Account (HRA, not flex spending)	<input type="text"/>
Medical - Exclusive Provider Organization (EPO)	<input type="text"/>
Dental (separate from medical plan)	<input type="text"/>
Prescription Plan (separate from medical plan)	<input type="text"/>
Vision (separate from medical plan)	<input type="text"/>
Short-term Disability (state plan)	<input type="text"/>
Short-term Disability (private plan)	<input type="text"/>
Long-term Disability	<input type="text"/>
Family Leave Insurance (state plan)	<input type="text"/>
Family Leave Insurance (private plan)	<input type="text"/>
Basic Life	<input type="text"/>
Supplemental Life	<input type="text"/>

Long-term Care

Employer-Paid Flexible
Spending Account (FSA)

Worker's Compensation

Accidental Death and
Dismemberment (AD&D)
Insurance

Travel Insurance

77. Please use this space to note if you have alternate payment arrangements for plans offered to employees' spouses/dependents/partners. For example, note here if your organization pays a set dollar amount towards health insurance, in lieu of a percent of the premium.

32. Insurance Benefits - Percentage Paid for Trustees

* 78. Does your organization pay a different percent of insurance premiums for TRUSTEES than it pays for employees?

- Yes
- No
- My organization does not provide any of the aforementioned insurance benefits for TRUSTEES.

33. Insurance Benefits - % Paid for Trustees Details

79. Please note approximately what PERCENT of the premium is paid by the organization for TRUSTEES for the plans that are offered by your organization.

NOTE: If your organization does not offer the plan, please leave the corresponding field blank. If your organization provides the plan, but does not pay any of the premium, please put a "0" in the corresponding field. If your organization provides the plan, but there is another payment arrangement (such as a set dollar amount), please leave the corresponding field blank and note the arrangement in the following question.

Medical - Traditional Indemnity Plan	<input type="text"/>
Medical - Preferred Provider Organization (PPO)	<input type="text"/>
Medical - Health Management Organization (HMO)	<input type="text"/>
Medical - Point of Service (POS)	<input type="text"/>
Medical - Health Reimbursement Account (HRA, not flex spending)	<input type="text"/>
Medical - Exclusive Provider Organization (EPO)	<input type="text"/>
Dental (separate from medical plan)	<input type="text"/>
Prescription Plan (separate from medical plan)	<input type="text"/>
Vision (separate from medical plan)	<input type="text"/>
Short-term Disability (state plan)	<input type="text"/>
Short-term Disability (private plan)	<input type="text"/>
Long-term Disability	<input type="text"/>
Family Leave Insurance (state plan)	<input type="text"/>
Family Leave Insurance (private plan)	<input type="text"/>
Basic Life	<input type="text"/>
Supplemental Life	<input type="text"/>

Long-term Care

Employer-Paid Flexible
Spending Account (FSA)

Worker's Compensation

Accidental Death and
Dismemberment (AD&D)
Insurance

Travel Insurance

80. Please use this space to note if you have alternate payment arrangements for plans offered to trustees. For example, note here if your organization pays a set dollar amount towards health insurance, in lieu of a percent of the premium.

34. Insurance Benefits - Percentage Paid for Trustees' Spouse

* 81. Does your organization pay a different percent of insurance premiums for TRUSTEES' SPOUSES/DEPENDENTS/DOMESTIC PARTNERS than it pays for employees?

- Yes
- No
- My organization does not provide any of the aforementioned insurance benefits for TRUSTEES' SPOUSES/DEPENDENTS/DOMESTIC PARTNERS.

35. Insurance Benefits - % Paid for Trustees' Spouse Details

82. Please note approximately what PERCENT of the premium is paid by the organization for TRUSTEES' SPOUSES/DEPENDENTS/DOMESTIC PARTNERS for the plans that are offered by your organization.

NOTE: If your organization does not offer the plan, please leave the corresponding field blank. If your organization provides the plan, but does not pay any of the premium, please put a "0" in the corresponding field. If your organization provides the plan, but there is another payment arrangement (such as a set dollar amount), please leave the corresponding field blank and note the arrangement in the following question.

Medical - Traditional
Indemnity Plan

Medical - Preferred
Provider Organization
(PPO)

Medical - Health
Management Organization
(HMO)

Medical - Point of Service
(POS)

Medical - Health
Reimbursement Account
(HRA, not flex spending)

Medical - Exclusive
Provider Organization
(EPO)

Dental (separate from
medical plan)

Prescription Plan (separate
from medical plan)

Vision (separate from
medical plan)

Short-term Disability (state
plan)

Short-term Disability
(private plan)

Long-term Disability

Family Leave Insurance
(state plan)

Family Leave Insurance
(private plan)

Basic Life

Supplemental Life

Long-term Care

Employer-Paid Flexible
Spending Account (FSA)

Worker's Compensation

Accidental Death and
Dismemberment (AD&D)
Insurance

Travel Insurance

83. Please use this space to note if you have alternate payment arrangements for plans offered to trustees' spouses/dependents/partners. For example, note here if your organization pays a set dollar amount towards health insurance, in lieu of a percent of the premium.

36. Insurance Benefits - Payment in Lieu of Coverage

* 84. Please indicate the amount (in dollars) of compensation offered to employees who waive participation in the organization's health plans.

NOTE: If your organization does not offer compensation to employees who waive participation in the organization's health plans, please put a "0" in the space provided.

Amount paid for waiver of
single coverage

Amount paid for waiver of
couple coverage

Amount paid for waiver of
family coverage

37. Insurance Benefits - Disability

* 85. Is participation in your organization's short-term disability insurance plan mandatory for employees?

- Yes
- No
- My organization does not provide a short-term disability insurance plan for employees.

* 86. Is participation in your organization's long-term disability insurance plan mandatory for employees?

- Yes
- No
- My organization does not provide a long-term disability insurance plan for employees.

* 87. Is participation in your organization's Family Leave Insurance plan mandatory for employees?

- Yes
- No
- My organization does not provide a Family Leave Insurance plan for employees.

88. Do you have more to add? Need to clarify a response? Please use the space below to provide comments/clarifications/explanations for insurance benefits provided to employees and other associated individuals.

38. Retirement

This section will ask you to provide details on retirement benefits that your organization provides to employees and trustees. Please complete these questions by indicating the benefits that are offered to the majority of employees in your organization, and please feel free to use the comment boxes after some of the questions to further explain/clarify your responses.

* 89. Does your organization have a retirement plan available to employees?

Yes

No

* 90. Does your organization have a retirement plan available to trustees?

Yes

No

* 91. Does your organization offer a defined benefit retirement plan? (A defined benefit retirement plan, often known as a pension, is a retirement account for which the organization puts forth all the money in exchange for a set payout when the employee retires.)

Yes

No

* 92. Does your organization offer a defined contribution retirement plan? (A defined contribution retirement plan, like a 401(k) or 403(b), requires the employee to contribute his or her own funds.)

Yes

No

93. If yes, indicate which types of plans are offered.

	Available to ALL full-time employees	Available to SOME full-time employees	Available to ALL part-time employees	Available to SOME part-time employees	Available to Trustees
Tax deferred savings plan (403b)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tax deferred savings plan (401k)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tax deferred savings plan (457b)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tax deferred savings plan (457f)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tax deferred savings plan (Simplified Employee Pension IRA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tax deferred savings plan (Savings Incentive Match Plan for Employees IRA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fixed dollar amount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cash Balance Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

* 94. Does the organization make any contributions to the defined contribution plan?

- Yes
 No

If yes, please specify the approximate expenditure per employee. Express as a % of salary, % of employee contribution, or as a \$ amount.

* 95. Does the organization require that contributions to the defined contribution plan be matched by the employee?

- Yes
 No

If yes, please specify the terms of the match.

* 96. Is there a vesting period to be eligible to collect the organization's contribution to the defined contribution plan?

Yes

No

If yes, what is the vesting period?

97. Please indicate the minimum age and minimum service requirements for employees to be eligible for retirement with full benefits.

* 98. Has your organization ever offered an early retirement incentive to employees?

Yes

No

If yes, please provide additional explanation.

39. Other Benefits

This section will ask you to provide details on other benefits that your organization provides to employees. Please complete these questions by indicating the benefits that are offered to the majority of employees in your organization.

* 99. Please indicate what other benefits you offer employees. Check all that apply.

- Employee Assistance Program
- Employee Wellness Program
- Exercise/Meditation Room
- Employer Paid Training/Professional Development
- Professional Development for the Chief Financial Officer, as required for continued CPA licensing
- Tuition Reimbursement
- 529 College Savings Plan
- Professional Organization Memberships
- Child Care Vouchers/Reimbursement
- Education Reimbursement for Dependents
- Elder Care Vouchers/Reimbursement
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Reimbursement for Prescription Drugs
- Use of an Automobile
- Reimbursement for Work-Related Auto Expenses
- Commuter Subsidy/Reimbursement Program
- Free Parking
- Use of a Mobile Phone
- Reimbursement for Mobile Phone Usage
- Provide Laptop
- Provide Ipad/tablet
- Flexible Work Week
- Sabbatical
- Meals/Refreshments
- Matching gifts for personal contributions
- None
- Other (please specify)

* 100. In general, to whom are the aforementioned benefits available?

- All employees
- Only CEO/Director/Administrator
- CEO/Director/Administrator AND senior staff
- My organization does not offer any of the aforementioned benefits.

Please describe any other CEO/Director/Administrator specific benefits not listed above.

* 101. Does your organization have a formal policy for allowing staff to work offsite either part-time or full-time (telecommute)?

- Yes, please specify
- No, but we allow staff to work remotely on an ad hoc basis
- No, we do not allow staff to work offsite
- Other, please specify

102. If you allow employees to work remotely, does your organization's worker's compensation insurance cover claims in an employees' home/remote office?

- Yes
- No

Please use the space below to provide additional explanation, if needed

* 103. Does your organization recognize tenure with longevity payments?

- Yes
- No

If yes, please indicate how the plan works along with the payment amounts.

* 104. Are contracts and/or severance agreements negotiated prior to hiring staff?

Yes

No

Please use the space below to provide additional explanation, if needed.

40. Retiree Benefits

This section will review the types of benefits that your organization provides to RETIRED employees and associated individuals. Please complete these questions by indicating the benefits that are offered to the majority of retired employees, and please feel free to use the comment boxes after some of the questions to further explain/clarify your responses.

* 105. Does your organization offer benefits--such as insurance (medical, dental, prescription, vision, life or long-term care) or other post-retirement benefits (bonuses, use of automobile, housing, subsidies, contributions to tax-deferred savings plans, etc.)--to retired employees and/or retired trustees?

Yes

No

41. Retiree Benefits - Insurance

* 106. Please indicate what types of insurance are available to RETIRED individuals associated with your organization. Check all that apply for each category of individual.

	Retired Employees	Retired Employees' Spouse/Dependent	Retired Employees' Domestic Partner	Retired Trustees	Retired Trustees' Spouse/Dependent/Domestic Partner
Medical - Traditional Indemnity Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical - Preferred Provider Organization (PPO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical - Health Management Organization (HMO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical - Point of Service (POS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical - Health Reimbursement Account (HRA, not flex spending)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical - Exclusive Provider Organization (EPO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical - Compensation in lieu of medical insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical - Reimbursement of medical expenses directly to individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental (part of medical plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental (separate from medical plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Plan (part of medical plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Plan (separate from medical plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision (part of medical plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision (separate from medical plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basic Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Retired Employees	Retired Employees' Spouse/Dependent	Retired Employees' Domestic Partner	Retired Trustees	Retired Trustees' Spouse/Dependent/Domestic Partner
Supplemental Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long-term Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
None (My organization does not offer any of the insurance plans listed above.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

42. Retiree Benefits - Insurance % Paid Details

107. Please note approximately what PERCENT of the premium is paid by the organization for RETIRED EMPLOYEES for the plans that are offered by your organization.

NOTE: If your organization does not offer the plan, please leave the corresponding field blank. If your organization provides the plan, but does not pay any of the premium, please put a "0" in the corresponding field. If your organization provides the plan, but there is another payment arrangement (such as a set dollar amount), please leave the corresponding field blank and note the arrangement in the following question.

Medical - Traditional
Indemnity Plan

Medical - Preferred
Provider Organization
(PPO)

Medical - Health
Management Organization
(HMO)

Medical - Point of Service
(POS)

Medical - Health
Reimbursement Account
(HRA, not flex spending)

Medical - Exclusive
Provider Organization
(EPO)

Dental (separate from
medical plan)

Prescription Plan (separate
from medical plan)

Vision (separate from
medical plan)

Basic Life

Supplemental Life

Long-term Care

108. Please use this space to note if you have alternate payment arrangements for plans offered to retired employees. For example, note here if your organization pays a set dollar amount towards health insurance, in lieu of a percent of the premium.

43. Retiree Benefits - Insurance for Retiree's Spouse

* 109. Does your organization pay a different percent of insurance premiums for RETIRED EMPLOYEES' SPOUSES/DEPENDENTS/DOMESTIC PARTNERS than it pays for retired employees?

- Yes
- No
- My organization does not provide any of the aforementioned insurance benefits for RETIRED EMPLOYEES' SPOUSES/DEPENDENTS/DOMESTIC PARTNERS.

44. Retiree Benefits - Insurance % Paid for Retirees' Spouse

110. Please note approximately what PERCENT of the premium is paid by the organization for RETIRED EMPLOYEES' SPOUSES/DEPENDENTS/DOMESTIC PARTNERS for the plans that are offered by your organization.

NOTE: If your organization does not offer the plan, please leave the corresponding field blank. If your organization provides the plan, but does not pay any of the premium, please put a "0" in the corresponding field. If your organization provides the plan, but there is another payment arrangement (such as a set dollar amount), please leave the corresponding field blank and note the arrangement in the following question.

Medical - Traditional Indemnity Plan	<input type="text"/>
Medical - Preferred Provider Organization (PPO)	<input type="text"/>
Medical - Health Management Organization (HMO)	<input type="text"/>
Medical - Point of Service (POS)	<input type="text"/>
Medical - Health Reimbursement Account (HRA, not flex spending)	<input type="text"/>
Medical - Exclusive Provider Organization (EPO)	<input type="text"/>
Dental (separate from medical plan)	<input type="text"/>
Prescription Plan (separate from medical plan)	<input type="text"/>
Vision (separate from medical plan)	<input type="text"/>
Basic Life	<input type="text"/>
Supplemental Life	<input type="text"/>
Long-term Care	<input type="text"/>

111. Please use this space to note if you have alternate payment arrangements for plans offered to retired employees' spouses/dependents/domestic partners. For example, note here if your organization pays a set dollar amount towards health insurance, in lieu of a percent of the premium.

45. Retiree Benefits - Insurance for Retired Trustees

* 112. Does your organization pay a different percent of insurance premiums for RETIRED TRUSTEES than it pays for retired employees?

- Yes
- No
- My organization does not provide any of the aforementioned insurance benefits for RETIRED TRUSTEES.

46. Retiree Benefits - Insurance % Paid for Retired Trustees

113. Please note approximately what PERCENT of the premium is paid by the organization for RETIRED TRUSTEES for the plans that are offered by your organization.

NOTE: If your organization does not offer the plan, please leave the corresponding field blank. If your organization provides the plan, but does not pay any of the premium, please put a "0" in the corresponding field. If your organization provides the plan, but there is another payment arrangement (such as a set dollar amount), please leave the corresponding field blank and note the arrangement in the following question.

Medical - Traditional
Indemnity Plan

Medical - Preferred
Provider Organization
(PPO)

Medical - Health
Management Organization
(HMO)

Medical - Point of Service
(POS)

Medical - Health
Reimbursement Account
(HRA, not flex spending)

Medical - Exclusive
Provider Organization
(EPO)

Dental (separate from
medical plan)

Prescription Plan (separate
from medical plan)

Vision (separate from
medical plan)

Basic Life

Supplemental Life

Long-term Care

114. Please use this space to note if you have alternate payment arrangements for plans offered to retired trustees. For example, note here if your organization pays a set dollar amount towards health insurance, in lieu of a percent of the premium.

47. Retiree Benefits - Insurance for Retired Trustees Spouse

* 115. Does your organization pay a different percent of insurance premiums for RETIRED TRUSTEES' SPOUSES/DEPENDENTS/DOMESTIC PARTNERS than it pays for retired employees?

- Yes
- No
- My organization does not provide any of the aforementioned insurance benefits for RETIRED TRUSTEES' SPOUSES/DEPENDENTS/DOMESTIC PARTNERS.

48. Retiree Benefits - Insurance % Paid for Retired Trustees Spouse

116. Please note approximately what PERCENT of the premium is paid by the organization for RETIRED TRUSTEES' SPOUSES/DEPENDENTS/DOMESTIC PARTNERS for the plans that are offered by your organization.

NOTE: If your organization does not offer the plan, please leave the corresponding field blank. If your organization provides the plan, but does not pay any of the premium, please put a "0" in the corresponding field. If your organization provides the plan, but there is another payment arrangement (such as a set dollar amount), please leave the corresponding field blank and note the arrangement in the following question.

Medical - Traditional
Indemnity Plan

Medical - Preferred
Provider Organization
(PPO)

Medical - Health
Management Organization
(HMO)

Medical - Point of Service
(POS)

Medical - Health
Reimbursement Account
(HRA, not flex spending)

Medical - Exclusive
Provider Organization
(EPO)

Dental (separate from
medical plan)

Prescription Plan (separate
from medical plan)

Vision (separate from
medical plan)

Basic Life

Supplemental Life

Long-term Care

117. Please use this space to note if you have alternate payment arrangements for plans offered to retired trustees' spouses/dependents/domestic partners. For example, note here if your organization pays a set dollar amount towards health insurance, in lieu of a percent of the premium.

49. Retiree Benefits - Other Benefits

* 118. Does your organization offer post-retirement benefits to executives and/or trustees? (Such as housing, subsidies, contributions to tax-deferred savings plans, etc.)

Yes

No

50. Retiree Benefits - Other Benefits Details

* 119. Please indicate what other post-retirement benefits you offer executives and/or trustees. Check all that apply.

	Bonus	Use of an Automobile	Housing	Subsidies	Contributions to tax- deferred savings plan (401k, 403b, Simple IRA)
Retired Executive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retired Trustee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

51. Retiree Benefits - Other Benefits Part Two

120. Do you have more to add? Need to clarify a response? Please use the space below to provide comments/clarifications/explanations for benefits provided to retired employees and other associated individuals.

52. Benefits Cost

This section will ask you to provide details on the cost of providing benefits to your organization.

* 121. Of your total personnel expenditures, please estimate what percentage will be spent on each of the following in 2020?

NOTE: The total must equal 100%.

% Total Gross Payroll (do not include bonuses or contracted staff)

% Health Insurance (medical, dental, vision, prescription)

% Other Insurance (STD, LTD, Life, etc.)

% Retirement Plan Contributions

% Other Benefits

122. Please use the space below to provide any comments/clarifications/explanations regarding your organization's personnel expenditures.

* 123. Does your organization communicate the cost of benefits with employees?

Yes

No

* 124. From 2019 to 2020, the per employee cost for health insurance in my organization has:

Increased

Decreased

Remained the same

* 125. Please indicate any cost containment measures your organization implemented since 2017 or intends to implement over the next 2 years. Check all that apply.

- Change insurance carriers to decrease cost
- Change insurance plans to decrease cost
- Eliminate most expensive plans
- Change from 100% employer paid benefits to a shared cost with employees
- Increase the employee's share of the benefit expense
- Offer some plans 100% employer paid and other more expensive plans partially paid by the employee
- Eliminate family benefit coverage
- Increase employee cost for family benefit coverage
- Increase employee share of out-of-pocket expenses
- Offer a high deductible plan with an employer paid flexible spending account
- Offer an opt-out provision for those who have other health insurance options
- Offer an incentive/payment to employees who opt-out of the health insurance plan
- Increase out-of-pockets costs for staff while the organization increases the pool in individual HRAs
- Offer less expensive medical plans (EPO, HSA)
- Change to PEO to offer more variety and better cost containment
- Renegotiate benefits within the plan.
- None
- Other (please specify)

53. Changes due to Coronavirus

126. What benefits, if any, has your organization changed in light of the COVID-19 pandemic (for example, offered remote work for the first time or to all employees, increased sick days allotted, etc.)? Please use the space below to explain any changes made to deal with the pandemic.

54. Final Thoughts

127. Do you have more to add? Need to clarify a response? Please use the space below to provide final comments/clarifications/explanations for ANY OF THE TOPICS mentioned in this survey.

55. No Paid Staff

Because your organization does not have any paid staff, you do not need to answer anymore questions, **but do not leave yet!** Please proceed to the next page to submit your data.

56. Final Page

You have reached the end of the 2020 Foundation Benefits Survey. Thank you for taking the time to complete this survey!

TO SUBMIT YOUR DATA, YOU MUST CLICK ON "SUBMIT SURVEY" AT THE BOTTOM OF THIS PAGE.

If you are not yet ready to submit your input, you may click "Exit this Survey" at the upper right corner of this page. Your data will be saved, but not submitted.

Many thanks again for your time and assistance. Your input is essential to producing the *2020 New Jersey Foundation Benefits & Salary Summary Report*, which is one of the most valued benefits of CNJG membership, and is an important and effective benchmarking tool for New Jersey's grantmaking community. Please look for the report to be released later this year. In the meantime, should you have any questions, please contact Craig Weinrich at craigweinrich@cnjg.org or 609.341.2022 x4215.