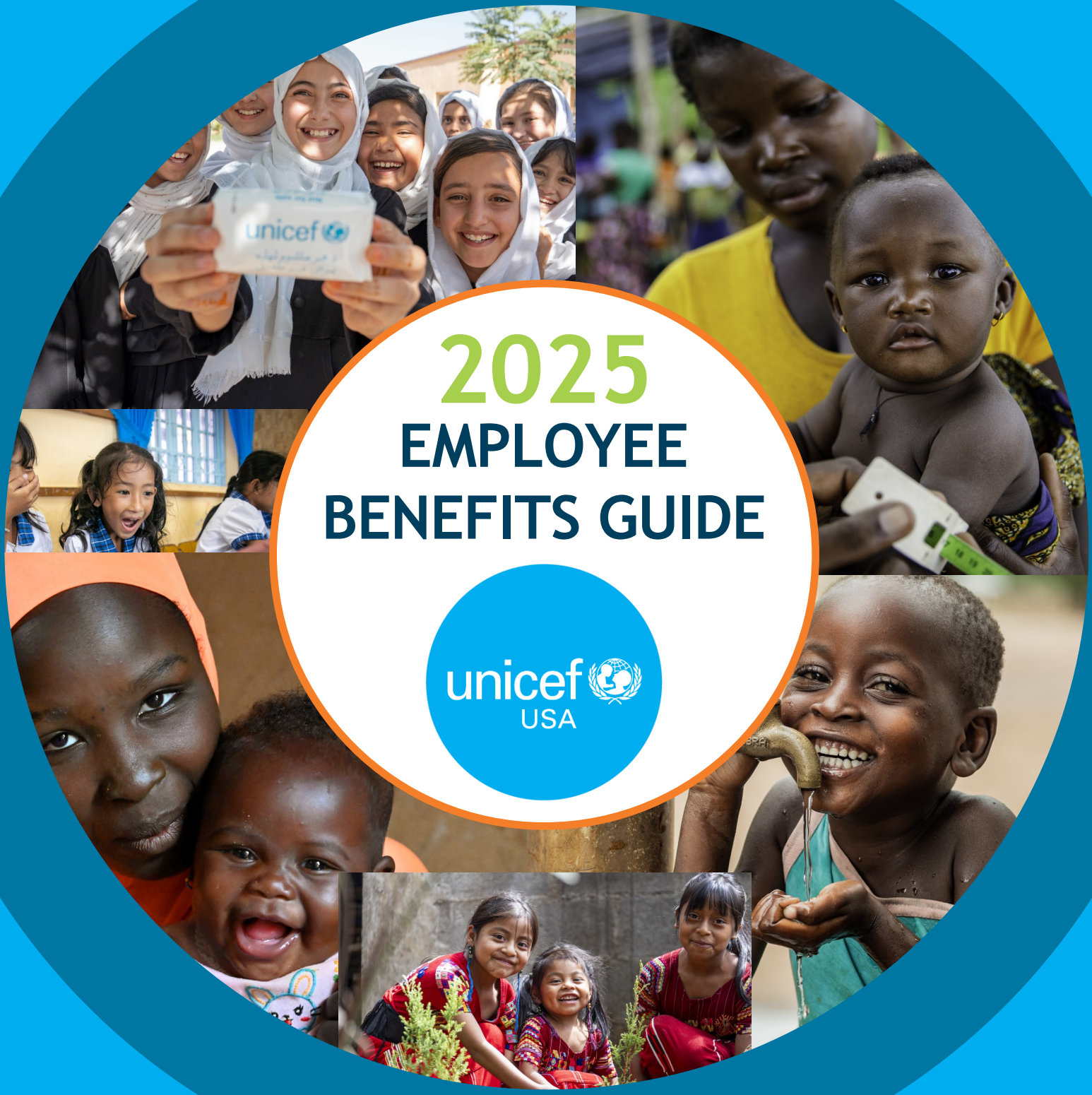

2025 EMPLOYEE BENEFITS GUIDE

unicef USA

2025 BENEFITS OVERVIEW

WELCOME TO THE 2025 UUSA BENEFITS PROGRAM

UNICEF USA recognizes the importance of benefits within the overall compensation package provided to all of our eligible employees. We have always focused not only on providing quality medical plans, but also on controlling the cost and financial risk for our employees.

NOT SURE HOW TO GET STARTED?

YOU MUST FIRST REGISTER ONLINE AT

ppienroll.com

You will receive step-by-step enrollment instructions from Sin Yee Yuen in People & Culture.

Until then, now is the perfect time to prepare by doing the following:

- ✔ Register Online at PPIENROLL
- ✔ Check that your personal information is accurate
- ✔ Input your Life Insurance Beneficiaries

In this booklet, you'll find easy-to-understand instructions to help you make your benefit decisions.

We are happy to have you as a member of the UNICEF USA family and look forward to a healthy and safe 2025.

TIP **REMEMBER! This is the one time of year you can make any adjustments you'd like for the upcoming plan year until Open Enrollment, unless you have a Qualifying Life Event.**

unicef USA

for every child

2025 AT A GLANCE

- Our Flexible Spending accounts and Health Reimbursement Arrangement have been taken over by Flores Associates effective October 2, 2024. FSA Enrollment will be handled via Paper Enrollment Form. See link on Page 7.

403B NEWS

- All eligible employees will automatically be enrolled to the 403b retirement plan with Principal, unless they elect otherwise.
- Annual automatic increase cap changing from 10% to 15%.
- There will be a one-time sweep to increase staff's 403b contribution by 1% for anyone with 1% to 14%.
- Workers aged 60-63 can boost catch up contributions to $11,250.
- All other catch up limits remain the same.

TABLE OF CONTENTS

Throughout this guide you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.

This Guide is for convenience only and is not intended to represent or provide a complete list of covered benefits or services.

Please refer to Policy Tech for Detailed Summary Plan Descriptions.

CONTACT INFORMATION

MEDICAL BENEFITS
Oxford Health Plans
Group # 1280511
www.myuhc.com
800.444.6222

DENTAL BENEFITS
Aetna
Group# 016350
www.aetna.com
877.238.6200

VISION BENEFITS
EyeMed
Group # 26-202673
www.eyemed.com
866.289.0614

Ameritas for ID Cards/Network Questions
800.659.2223

403(B) RETIREMENT PLAN
Principal Financial Group
Group # 533248
www.Principal.com
800-986-3343

LIFE & DISABILITY BENEFITS
UNUM
LTD, Life, ADD & Leave Group # 916814
Life Claims—800.445.0402
NY DBL Group # 916816
www.portal.unum.com
800.421.0344

FLEXIBLE SPENDING ACCOUNTS
Flores & Associate
Www.flores247.com
800.532.3327

CBIZ BENEFITS SERVICE TEAM
pabenefits@cbiz.com
1.800.820.5090

UUSA ASSISTANT DIRECTOR, BENEFITS
Sin Yee Yuen
syuen@unicefusa.org
212.922.2610

MEDICAL INSURANCE

YOUR HEALTH PLAN OPTIONS

As a an eligible employee of UNICEF USA you have the choice between two medical plan options: Option 1 EPO or OPTION 2 POS.

Both plans provide comprehensive coverage, both utilize the Oxford Freedom Network locally and access the United Choice Plus network, one of the largest national networks in the U.S. While Option 2 POS provides some coverage when using out-of-network providers, you can save money by using in-network providers because Oxford and United Healthcare have negotiated significant discounts with them.

If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and Oxford's UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance. These charges can be substantial.

Option 1 EPO offers you significantly lower premiums than the Option 2 POS.

FREQUENTLY ASKED QUESTIONS

How many hours do I need to work to be eligible for insurance benefits?

You must be an active employee working a minimum of 20 hours per week on a regular basis.

Will I receive a new Medical ID card?

New Participants will receive ID cards in the mail and can access online using the UHC Mobile App.

Does the Out of Network deductible run on a calendar year or policy year basis?

A calendar year basis.

How long can I cover my dependent children?

Dependent children are eligible until the end of the month in which they turn age 26.

I just got hired. When will my benefits become effective?

Your medical insurance benefit will begin on the 1st of the month following date of hire.

Benefits Key Terms Explained

HOW TO GET STARTED

1. SELECT YOUR MEDICAL PLAN

- OPTION 1:OXFORD FREEDOM EXCLUSIVE DIRECT EPO
- OPTION 2: FREEDOM DIRECT POS

BOTH OPTIONS INCLUDE:

- Routine preventive exams covered at 100%.
- The same In Network Benefits.
- The Same Covered Services.
- The Same Network.

OPTION 2 MAY BE FOR YOU IF THE FOLLOWING IS TRUE:

- You do not use In Network Providers.
- You would rather pay more in monthly premiums for the rare occurrence an out of network provider is desired.

HOW DO I FIND A HEALTHCARE PROVIDER:

- Click Here: Find A Provider
- If you are registered, sign in. If not, Search General Provider List,
- Click on the type of provider you are looking for,
- Click on Employer and Individual Plans,
- Scroll down to Oxford Health Plans,
- Click on Freedom with Choice Plus, and;
- Enter the Zip Code you are searching in.

CARE OPTIONS & WHEN TO USE THEM

YOUR CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting www.myuhc.com

Primary Care vs. Urgent Care vs. ER

PRIMARY CARE

- Routine, primary/preventive care
- Non-urgent treatment
- Chronic disease management

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out of pocket.

VIRTUAL HEALTH

- Cold/flu
- Diarrhea
- Fever
- Rash
- Sinus problems

Oxford Virtual Visits lets you see and talk to a doctor from your mobile device or computer without an appointment, anytime and anywhere! Go to uhc.com/virtualvisits and seek care from the comfort and convenience of your home or wherever you are.

CONVENIENCE CARE

- Common infections (ear infections, pink eye, strep throat & bronchitis)
- Flu shots
- Pregnancy tests
- Vaccines
- Rashes
- Screenings

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency. They are often located in malls or retail stores (such as CVS, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

- Sprains
- Small cuts
- Strains
- Minor infections
- Sore throats
- Mild asthma attacks
- Back pain or strains

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office. Outside regular office hours — or if you can't be seen by your doctor immediately — you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

An emergency medical condition is any condition (including severe pain) which you believe that, without immediate medical care, may result in serious injury or is life threatening. Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

If you believe you are experiencing a medical emergency
Go to the nearest emergency room or call 9-1-1
Even if your symptoms are not described here.

MEDICAL INSURANCE

OXFORD HEALTHCARE OPTIONS

As a an eligible employee of UNICEF USA you have the choice between two medical plan options: Option 1 EPO or OPTION 2 POS.

Both plans provide comprehensive coverage and the same in network benefits. Both utilize the Oxford Freedom Network locally and access the United Choice Plus network, one of the largest national networks in the U.S. While Option 2 POS provides some coverage when using out-of-network providers, you can save money by using in-network providers because Oxford and United Healthcare have negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and Oxford's UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance. These charges can be substantial.

The UNICEF USA Health Reimbursement Arrangement will reimburse members up to 80% of the Inpatient Hospital Copayment when submitted to Flores Associates.

Oxford Health Plans	Option 1 - EPO Exclusive Freedom Direct Plan In-Network	Option 2 - POS Freedom Direct Plan In-Network
Deductible - Individual / Family	None	None
Coinsurance (Plan Pays)	100%	100%
Maximum Out of Pocket - Individual / Family	$2,500 / $5,000	$2,500 / $5,000
Office Visits		
Preventive Care	No Charge	No Charge
Primary Care Physician / Specialist Copay	$25 / $40	$25 / $40
Diagnostic Lab / X-Ray	No Charge	No Charge
Urgent Care	$40 Copay	$40 Copay
Hospital Visits		
Inpatient Care (Facility)	$500 Copay	$500 Copay
Outpatient Surgery	$250 Copay	$250 Copay
Major Diagnostics & Imaging	No Charge	No Charge
Emergency Room	$300 Copay	$300 Copay
Prescription Drug	**$100 Deductible—Tier 1 & 2**	**$100 Deductible—Tier 1 & 2**
Retail Tier 1 / 2 / 3 Copay	$15 / $35 / $75	$15 / $35 / $75
Mail Order (90-day supply)	2.5x Retail Copay	2.5x Retail Copay
	Out-of-Network	**Out-of-Network**
Deductible		
Individual / Family	In Network Benefits Only	$400 / $800
Coinsurance (Member Pays)		20%
Out-of-Pocket Maximum		
Individual / Family	In Network Benefits Only	$1,400 / $2,800

FIND A NETWORK PROVIDER

This is not a complete list of benefits, please refer to Policy Tech for Summary Plan Descriptions.

(1) Family Deductible is Cumulative. No single individual within a EE+1 or Family coverage level is responsible for more than the Individual Deductible amount.

(2)Maximum out of Pocket Limit is Cumulative. No single individual within a EE+1 or Family coverage level is responsible for more than the individual Out of Pocket Maximum.

Both options are detailed in Oxford's 2025 Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to your certificate.

FLEXIBLE SPENDING ACCOUNTS (FSA)

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars. You can also pay for dependent health care, even if you choose single (vs. family) coverage. The total amount of your annual health care election is available to you up front, reducing the chance of having a large out-of-pocket expense early in the plan year. **Be aware — any unused portion of the account above the 2025 healthcare roll-over maximum of $660 is forfeited at the end of the plan year.**

Click here for a sample list of Healthcare FSA Eligible Expenses

What Is A Flexible Spending Account?

DEPENDENT CARE EXPENSE ACCOUNT

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes). Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

HOW THE HEALTH CARE HEALTHCARE FLEXIBLE SPENDING ACCOUNT WORKS

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to Flores Associates.

2025 IRS Maximum Contributions

Health Care Flexible Spending Account	$3,300 max
Dependent Care Expense Account*	$5,000 max

2. SELECT YOUR FSA ACCOUNTS

- HEALTH CARE FLEXIBLE SPENDING ACCOUNT
- DEPENDENT CARE EXPENSE ACCOUNT
- PARKING & TRANSIT

PARKING & TRANSIT

Commuter Benefits allow you to conveniently pay for eligible work-related transit and parking commuting costs with pre-tax dollars deducted from your paycheck.

Transit Accounts can be used for train and bus passes up to $325 a month on a pre-tax benefit.

Parking Accounts can be used for parking at or near your work location or mass transportation up to $325 a month on a pre-tax benefit.

You may participate in one or both accounts. The accounts are separate. Per IRS regulations, you cannot use money in your Transit Account to pay for parking expenses, or vice versa. Transit dollars are no longer available as of the date of termination.

To Enroll In FSA

Complete:

2025 UUSA FSA Enrollment Form

Complete the form for all accounts for which you would like to enroll.

DENTAL INSURANCE

3. REVIEW AND SELECT YOUR DENTAL PLAN

AETNA DENTAL FREEDOM OF CHOICE

UNICEF USA offers a unique plan enabling you to switch between DMO and PPO benefits during the year. You can switch plans every month if you would like. If you do so by the 15th of the month, your change will be effective the first of the next month. Both include comprehensive dental coverage with the PPO offering coverage both in and out-of-network. (DMO provider list is updated monthly, your name may not appear in month one)

The DMO provides lower out of pocket costs, but requires you to select a Primary Care Dentist (PCD) and receive in-network referrals from your PCD for specialty care, you are not covered out of network.

When using the PPO it is always to your advantage to utilize a network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding Aetna's negotiated fees, plus any deductible and coinsurance associated with your procedure. This can be costly.

What Is Dental Insurance?

	Aetna DMO	Aetna Dental PPO	
	In-Network	**In-Network**	**Out-of-Network**
Deductible Individual / Family (Basic & major)	N/A	$50	
Annual Maximum	N/A	$2,500 Per Person	
	Carrier Pays	**Carrier Pays**	
Diagnostic / Preventive Services ■ Oral Evaluations / Cleanings / X-Rays / Fluoride Treatments ■ Emergency Treatment (for temporary pain relief)	$0 Office Visit Most Services Covered 100%	100%	100%
Basic Services ■ Fillings / Endodontics / Periodontics ■ Simple & Surgical Extractions	Fee Schedule	80%	80%
Major Services ■ Single Crowns | Inlays/Onlays ■ Bridges & Dentures | Prosthodontics	Fee Schedule	50%	50%
Orthodontia Services ■ Diagnostics & Treatment (Child through age 19)	None	50% up to the $1,000 lifetime maximum	

This is not a complete list of benefits, please refer to Policy Tech for Summary Plan Descriptions.

CLICK HERE TO FIND AN AETNA DENTAL PROVIDER

Need Member Services? Call 1.877.238.6200

1. If already a member, Log In.
2. If not: Go to Guests
3. Click on "Plan from an employer"
4. Enter your ZIP Code & Click Search
5. Select a Plan
   - ✔ For DMO enter DMO/DNO
   - ✔ For PPO enter Dental PPO/PDN

VISION INSURANCE

4. REVIEW THE VISION PLAN

EYEMED VISION PLAN ADMINSITERED BY AMERITAS

Vision coverage is provided to all eligible employees and their families at no cost. The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

Also, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers. Call 1.800.988.4221 for more information.

What Is Vision Insurance?

Benefit	In Network	Out of Network
Service Frequency	12 Months	12 Months
Exam	$10	Up to a $40 Allowance
Retinal Imaging	Up to $39	Not Covered
Basic Lenses (pair)		
Single Vision	$25 Copay	Up to $30 Reimbursement
Bifocal	$25 Copay	Up to $50 Reimbursement
Trifocal	$25 Copay	Up to $70 Reimbursement
Frame | Frequency	24 Months	24 Months
Eyeglass Frame Allowance	$130 Allowance/20% off Balance	Up to $91 Reimbursement
Contact Lenses		
Elective Conventional	$130 Allowance/15% off Balance	Up to $91 Reimbursement
Elective Disposable	$130 Allowance Only/100% off Balance	Up to $91 Reimbursement
Non-Elective Contact Lenses	$0 Copay/100%	Up to $210 Reimbursement
Eyeglass Lens Enhancements		
Factory Scratch Coating	$15 Copay	Not Applicable
Polycarbonate Lenses Children under 19	$0 Copay	Not Applicable
Transitions Lenses	20% off Retail Price	Not Applicable

This is not a complete list of benefits, please refer to Policy Tech for Summary Plan Descriptions.

FIND AN EYEMED VISION PROVIDER **Select the Insight Network** INDEPENDENT PROVIDER NETWORK LENSCRAFTERS OPTICAL PEARLE VISION

Additional Benefits apply:

- Receive 40% off an additional pair of prescription eyeglasses
- Receive 20% off non-covered items including non-prescription sunglasses
- You may have additional benefits, log into www.eyemed.com for more information
- Download the EyeMed members app.

Call Ameritas only for ID Card or Network Information

2025 EMPLOYEE CONTRIBUTIONS

Single Coverage Contributions

Employees Earning	EPO Single	Annual	POS Single	Annual	Dental Plan	Vision Plan
$0 - $59,999	$45.80	$1,191	$83.34	$2,167	$0.00	$0.00
$60,000 - $89,999	$60.01	$1,560	$99.12	$2,577	$0.00	$0.00
$90,000 - $149,999	$67.93	$1,766	$107.90	$2,805	$0.00	$0.00
$150,000 or More	$91.68	$2,384	$134.25	$3,491	$0.00	$0.00

Family Coverage Contributions

Employees Earning	EPO Family	Annual	POS Family	Annual	Dental Plan	Vision Plan
$0 - $59,999	$86.69	$2,254	$173.00	$4,498	$0.00	$0.00
$60,000 - $89,999	$128.17	$3,332	$210.62	$5,476	$0.00	$0.00
$90,000 - $149,999	$148.18	$3,853	$231.60	$6,022	$0.00	$0.00
$150,000 or More	$195.86	$5,092	$284.52	$7,398	$0.00	$0.00

Employee contributions are bi-weekly

LIFE & DISABILITY BENEFITS

BASIC LIFE AND AD&D

UNICEF USA provides up to 3x your annual salary to a maximum of $515,000 in Guaranteed Issue Basic Life and Accidental Death & Dismemberment (AD&D) insurance at no cost to you.

Eligible Staff can elect additional amounts up to $1,000,000 with Evidence of Insurability.

What Is Life And AD&D Insurance?

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability insurance is managed by UNUM. Your disability payment of $170 per week should be reimbursed back to UNICEF USA as you are eligible to receive 100% of your gross salary through the UNICEF USA Leave program after three months of employment.

Benefits are paid after a waiting period of 7 Days and last for 26 weeks from the date of disability.

LONG-TERM DISABILITY INSURANCE

Long-Term Disability insurance is covered by UNUM. UNICEF USA pays 100% of the premium cost. The plan benefit is 66.67% of basic monthly earnings up to a maximum of $10,000 per month.

The benefits begin after a 180 day waiting period of disability, during which time you would be covered under Short Term Disability. Benefits are payable based on continued disability and could continue up to the Social Security Normal Retirement Age.

What Is Disability Insurance?

Please see the Specific Certificate of Coverage for details.

LEAVE ADMINISTRATION

6. LEAVE REQUESTS

- LEAVE REQUESTS ADMINISTERED BY UNUM
- KEEP THIS INFORMATION FOR WHEN YOU REQUEST LEAVE

IF YOU ARE REQUESTING LEAVE, WHETHER:

The Family and Medical Leave Act (FMLA)

Entitles eligible employees to take unpaid, job-protected leave for specified family and medical reasons. You must be employed for one full year and have worked 1250 hours. You are eligible for up to 12 work weeks of leave in a 12-month period for one of more of the following reasons:

- Birth of a child or placement of a child for adoption or foster care ;
- To care for a spouse, child or parent who has a serious health condition;
- For a serious health condition that makes you unable to perform the essential functions of your job; or
- For any qualifying exigency arising from a spouse, child or parent in the military on covered active duty or call to covered active duty status. A 26 work week benefit during a single 12 month period is also available to care for a covered service family member with a serious injury or illness

New York Family Paid Leave*

Provides New York employees up to twelve weeks of job protected Paid Family Leave where employees can receive a percentage of your average weekly to a set maximum per week. Benefits are available to bond with a newly born, adopted or fostered child. Care for a family member with a serious health condition or, assist loved ones when a spouse, domestic partner, child or parent is deployed abroad on active duty. More information on NY Family Leave is available or www.paidfamilyleave.ny.gov/2025

Leaves provide Job Protection, Continued Health Insurance under the same terms as active employees.

Or, Any Other Covered Leave:

- ✔ Bereavement
- ✔ Military
- ✔ Jury Duty
- ✔ Parental Leave
- ✔ Personal Leave

Notify Sin Yee Yuen in People & Culture that you may have a situation that requires you to be out of the office, then click on the portal below and Register:

HTTPS://PORTAL.UNUM.COM

FOR ALL LEAVE REQUESTS GO TO THE PORTAL BELOW AND REGISTER:

HTTPS://PORTAL.UNUM.COM

QUESTIONS?

To Register provide:

- Name, DOB, Social Security, Phone, Personal Email
- Verify your ID
- Select state of residence
- Create your password

Select your Leave Reason

- Select your event dates
- Confirm your employment data
- Provide physician information
- Register Leave

Click Here for more Detailed Information on Managing your Leave through the Employee Portal

***Full-time employees**, who work a regular schedule of 20 or more hours per week, are eligible for Paid Family Leave after 26 consecutive weeks of employment.

7. REVIEW THE 403(B) PLAN

OUR 403 (B) PLAN IS MANAGED BY PRINCIPAL

UNICEF USA believes every employee should participate in saving money for their retirement and offers a very competitive 403(b) program through Principal Financial. Your contributions to the 403 (b) plan are deducted pre-tax and pre-FICA from your paycheck. An employee is eligible to participate in the 403 (b) plan on the first day of employment.

All eligible employees will automatically be enrolled to the 403b retirement plan with Principal, unless they elect otherwise. Annual automatic increase will occur beginning January 1st of 1% up to 15%.

What Is a 403 (b) Plan?

Employees will receive a welcome email directly from Principal along with link to register and enroll to the retirement plan.

The annual elective deferral limit for 403(b) plan employee contributions is $23,500 for 2025. Employees age 50 or older may contribute up to an additional $7,500 for a total of $31,000. Workers aged 60-63 can boost catch up contributions to $11,250 for a total of $34,750.

Upon completion of one year of service with UNICEF USA, employees are entitled to an employer's contribution of 4% of their base pay (regardless if they contribute to the plan or not) and match employee contribution up to 4% of base pay beginning on the 1st of the following month.

All UUSA employer contributions are subject to a 4 year vesting schedule.

Online First Time Users, go to **principal.com/Welcome**

- Select **Get Started**
- Enter your first name, last name, date of birth, mobile phone number (this is the quickest way to verify your identity), and your ID number (this is either your Social Security number or a specific ID provided by your employer) or ZIP code.
- Agree to do business electronically and click **Continue**

If you don't provide your mobile phone number, you'll need to answer a few personal questions as an alternative way to confirm it's really you:

- Create a unique username
- Set a secure password
- Add your email address
- Select and answer three security questions to use if you need to call us

You now have access to your online account, and you'll get a confirmation email within a few minutes.

The first time you log in, you'll need to choose where we send you **verification codes** (text message, voice call, or authentication app) and how often you want to use them.

TIPS ON HOW TO SAVE SMART FOR RETIREMENT:

- Start **NOW**. Don't wait. Time is critical.
- Start small, if necessary. Even small contributions can make a big difference given enough time and the right kind of investments.
- Use automatic deductions from your payroll or your checking account for deposit into mutual funds, your IRA or other investment vehicles.
- Save regularly. Make saving for retirement a habit.
- Be realistic about investment returns. Never assume that a year or two of high market returns (or market declines) will continue indefinitely.
- Roll over retirement account money if you change jobs.
- Don't dip into retirement savings.

Questions?

Having trouble setting up your login? Give Principal a call at **800-986-3343.**

Care.com + LifeCare

CARE.COM

Care.com provides employees access to a comprehensive suite of family care benefits. With Care.com membership, employees have unlimited access to the leading online community for finding family care and an industry leader in safety.

- Enroll and access care.com through a dedicated website, 24/7 access via desktop of mobile device.
- Find help for ongoing and one-time family care needs for children, adults, pets, tutoring, distance learning, housekeeping and more.
- Detailed caregiver profiles include experience, availability, reviews, and ratings
- All caregivers must complete an annual background check, CareCheck
- Employees only pay for the care they hire on Care.com and additional background checks, if desired.
- Available in over 20 countries.

All individual caregivers on the platform must complete a background check known as CareCheck which includes:

- Social Security Number trace
- Multi Jurisdictional criminal database search
- National Sex Offender public website search
- Federal and county level criminal records search
- Additional background check options re available for purchase by caregivers and families seeking care.

Care.com/Safety hosts a resource center for families and caregivers to access up to date safety resources including:

- Information on CareCheck and additional background checks available for purchase.
- Guidelines on monitoring applications and messages
- Covid-19 safety protocols
- Seeker safety guidelines for caregivers

Click here for more information:

unicefcare.com

You will need to use your UNICEF work email address to register and login.

Please see the Specific Certificate of Coverage for details.

GLOSSARY OF MEDICAL TERMS

INSURANCE TERMS

Copays—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. The out of pocket maximum includes all copays, deductibles and coinsurance.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

MEDICAL TERMS

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

IMPORTANT NOTICES

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from the United States Fund for UNICEF about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Oxford Health Plans and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The United States Fund for UNICEF has determined that the prescription drug coverage offered by the Oxford Health Plans health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current United States Fund for UNICEF coverage **may** be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the UNICEF USA medical plan, **be aware that you and your dependents may not be able to get this coverage back**.

IMPORTANT NOTICES

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the United States Fund for UNICEF and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the United States Fund for UNICEF changes. You also may request a copy of this notice at any time.

Contact: Sin Yee Yuen 212-922-2610

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit http://www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at http://www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: October 14, 2024
Name of Entity/Sender: Sin Yee Yuen
Contact--Position/Office: Assistant Director Benefits
Address: 125 Maiden Lane, New York N.Y. 10038

IMPORTANT NOTICES

MEDICAID CHIP NOTICE

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility—

ALABAMA - Medicaid	ALASKA - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS - Medicaid	**CALIFORNIA - Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA - Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

IMPORTANT NOTICES

GEORGIA - Medicaid	INDIANA - Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA - Medicaid and CHIP (Hawki)	**KANSAS - Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY - Medicaid	**LOUISIANA - Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE - Medicaid	**MASSACHUSETTS - Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA - Medicaid	**MISSOURI - Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA - Medicaid	**NEBRASKA - Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

IMPORTANT NOTICES

NEVADA - Medicaid	NEW HAMPSHIRE - Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY - Medicaid and CHIP	**NEW YORK - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA - Medicaid	**NORTH DAKOTA - Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA - Medicaid and CHIP	**OREGON - Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA - Medicaid and CHIP	**RHODE ISLAND - Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA - Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS - Medicaid	**UTAH - Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT- Medicaid	**VIRGINIA - Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON - Medicaid	**WEST VIRGINIA - Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - Medicaid and CHIP	**WYOMING - Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

IMPORTANT NOTICES

INITIAL COBRA NOTICE

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to: Sin Yee Yuen in People & Culture

IMPORTANT NOTICES

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions -

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

Keep your Plan informed of address changes -

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

Plan contact information -

Sin Yee Yuen

212.922.2610

syuen@unicefusa.org

This notice is intended as a brief outline; please see People & Culture for more information.

IMPORTANT NOTICES

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

If you have had, or are going to have, a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following In Network deductibles and coinsurance apply: $250 Copay Per Visit Outpatient, $500 Copay Per Inpatient Stay. If you would like more information on WHCRA benefits, contact Sin Yee Yuen 212.686.5522

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether he/she was covered by our group health plan. These employees should expect to receive their Form 1095-C in early March 2025. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

To request special enrollment or obtain more information, contact People & Culture.

IMPORTANT NOTICES

Expanded Women's Preventative Care

In plan years starting with June 1, 2013, the following preventive services will be covered at no cost-sharing under Preventive Services for Women as per the Affordable Care Act.

Well-woman visits	Well-woman preventative care visit annually for adult women to obtain the recommended preventative services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care. This well-woman visit should, where appropriate, include other preventative services listed in this set of guidelines, as well as others referenced in section 2713.	Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventative services, depending on a woman's health status, health needs, and other risk factors.
Screening for gestational diabetes	Screening for gestational diabetes	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes
Human papillomavirus testing	High-risk human papillomavirus DNA testing in women with normal cytology results	Screening should begin at 30 years of age and should occur no more frequently than every 3 year
Counseling for sexually transmitted infections	Counseling on sexually transmitted infections for all sexually active women	Annual
Counseling and screening for human immune-deficiency virus	Counseling and screening for human immune-deficiency virus infection for all sexually active women	Annual
Contraceptive methods and counseling	All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity	As prescribed
Breastfeeding support, supplies, and Counseling	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment	In conjunction with each birth
Screening and counseling for interpersonal and domestic violence	Screening and counseling for interpersonal and domestic violence	

MARKETPLACE COVERAGE OPTIONS

PART A: General Information

When key parts of the health care law took effect in 2014, there became a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2023 for coverage starting as early as January 1, 2024.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. [1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact the United States Fund for UNICEF HR department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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1 An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

MARKETPLACE COVERAGE OPTIONS (CONT.)

PART B: Information About Health Coverage Offered By Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Employer Name: United States Fund for UNICEF	**Employer Identification Number (EIN):** 13-1760110
Employer Address: 125 Maiden Lane New York, NY 10038	**Employer Phone Number:** 212.686.5522
Who can we contact about employee health coverage at this job? Sin Yee Yuen	**Phone Number:** 212.922.2610 **Email Address:** syuen@unicefusa.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

Eligible employees are:

- ✓ Active employees, working a minimum 20 hours per week on a regular basis. Employees will be effective the First day of the month, following date of employment.

- With respect to dependents:

- ✓ We do offer coverage. Eligible dependents are: Spouse, Dependent Children and Qualified Domestic Partners.

✓ This medical and prescription coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Above is the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

IMPORTANT NOTICES

Statement Regarding UUSA Group Health & Welfare Plan Electronic Disclosures

As an individual entitled to receive benefits under the UUSA Group Health & Welfare Plan Employee Benefits Plan (the "Plan"), you also have the right to be provided with specific documents required by ERISA. We intend to provide the following documents to you via electronic delivery as described below:

- Summary Benefits of Coverage
- Summary Plan Description
- Summary Annual Report
- Any documents required to be furnished under ERISA Section 104(b)(4) on request by a participant or beneficiary of the Plan or made available under ERISA Section 104(b)(2).

Description of Electronic Delivery Method

Wired at Work:" Since access to the Natixis electronic information system is an integral part of duties as an employee, and you have the ability to access electronic documents at any location where you are reasonably expected to perform your duties as an employee. We will provide these required documents to you as attachments to an e-mail which we will send to the your corporate email address. These documents are also provided via link at New Hire and within the required timeframes as per ERISA

You have a right to request this information be sent to the e-mail address you specify. If your preferred email is different, you must notify us in writing by sending an email to Sin Yee Yuen with a subject line that says ***Change in Email for Electronic Disclosure***.

Please see the detailed Summary Plan Descriptions for a complete understanding of your rights under ERISA

2025 EMPLOYEE BENEFITS

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