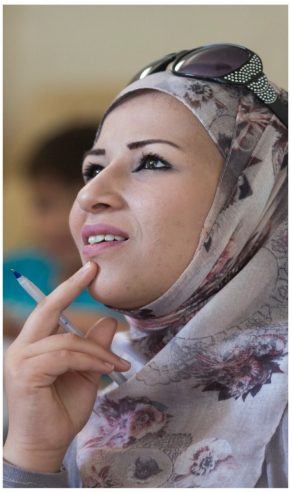
YOUR 2022 BENEFITS GUIDE

Delivering Benefit Choices with **You** in Mind



Plan Year: January 1, 2022 — December 31, 2022

WOMEN FOR WOMEN INTERNATIONAL

ABOUT THIS GUIDE

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan description (SPD), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail.

WOMEN FOR WOMEN INTERNATIONAL

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BENEFITS AT A GLANCE

Women for Women International is committed to providing employees with a benefits package that is both comprehensive and competitive. Our benefits offer health coverage and a degree of financial security to our employees and their families. This guide provides a general overview of your benefit choices and enrollment information to help you select the coverage that is right for you.

MEDICAL BENEFITS
CARRIER: CAREFIRST / DC HEALTH LINK
REFERENCE PLAN: BLUE CHOICE HSA GOLD - DEDUCTIBLE $1,500 / $3,000
OVER 59 PLANS TO CHOOSE FROM

DENTAL BENEFITS
CARRIER: AMERITAS
CORE PLAN: CALENDAR MAX $1,500 - DEDUCTIBLE: $50 / $150
BUY-UP PLAN: CALENDAR MAX $2,000 - DEDUCTIBLE: $50 / $150

VISION BENEFITS
CARRIER: UNITEDHEALTHCARE
EYE EXAM: $15 COPAY
FRAMES: $130 ALLOWANCE + 30% OFF BALANCE

LIFE BENEFITS
CARRIER: LINCOLN FINANCIAL
LIFE AND AD&D: 1X TIMES ANNUAL SALARY; MAX $150,000
LONG-TERM: 60% OF MONTHLY SALARY; MAX $5,000

ADDITIONAL BENEFITS
401K: 2022 IRS LIMIT $20,500 + $6,500 IF OVER 50
FLEXIBLE SPENDING ACCOUNTS: $2,850 HEALTH CARE FSA & LIMITED PURPOSE FSA LIMIT / $5,000 DEPENDENT CARE LIMIT
TRANSIT AND PARKING: $280 LIMIT / WFW CONTRIBUTES $40

ELIGIBILITY AND ENROLLMENT

If you are a full-time employee regularly scheduled to work at least 30 hours per week, you are eligible to participate in the benefit plans upon meeting eligibility requirements. Most benefits become effective on the first of the month following your date of hire.

Your dependents are also eligible based on the following guidelines:

- Your spouse/domestic partner
- Your dependent children up to age 26 regardless of marital or student status for medical, dental and vision
- Your unmarried children of any age who are incapable of supporting themselves due to a mental or physical disability and who are dependent on you

MAKING CHANGES DURING THE YEAR

Choose your benefits carefully. Medical, dental and vision contributions are made on a pre-tax basis and IRS regulations state that you have to experience a qualified life event in order to make changes during the plan year.

Qualified life events include but are not limited to:

- Marriage or divorce
- Death of your spouse/partner or dependent
- Birth or adoption of a child
- Your spouse/partner terminating or obtaining new employment (that affects eligibility for coverage)
- You or your spouse/partner switching employment status from full-time to part-time or vice versa (that affects eligibility for coverage)
- Significant cost or coverage changes
- Your dependent no longer qualifies as an eligible dependent

You must notify and submit any applicable forms and/ or documentation to Human Resources within 30* calendar days of the event. Human Resources will review your request and determine whether the change you are requesting is allowed. Only benefit changes which are consistent with the qualified life event are permitted.

**60 calendar days if you, your spouse/partner, or eligible dependent child loses coverage under Medicaid or a State Children's Health Insurance Program (CHIP) or becomes eligible for state-provided premium assistance.*

ENROLLMENT PERIODS

NEWLY HIRED EMPLOYEES

As a newly hired employee of Women for Women International, you become eligible for most benefits the first of the month following your date of hire, for medical if hired on the first of the month your benefits begin on your date of hire. You have 30 days from your hire date to enroll.

ANNUAL ENROLLMENT

As a benefits eligible employee, you have the once-a-year opportunity to enroll in or make changes to your benefit plans during our annual enrollment period unless you experience a qualified life event.

Our benefits plan year runs from **January 1, 2022 - December 31, 2022.**

PAYING FOR YOUR BENEFITS

Some benefits are provided to you at no cost by Women for Women International. The cost of other benefits is shared by you and Women for Women International.

Having benefit options available means you can build your benefits to meet your needs and your lifestyle.

BENEFIT	WHO PAYS
Medical / Prescription	Women for Women & You
Dental	Women for Women & You
Vision	Women for Women & You
Basic Life and AD&D	Women for Women
Long-Term Disability	Women for Women
Employee Assistance Program (EAP)	Women for Women
Flexible Spending Accounts (FSA)	You
Health Savings Account (HSA)	Women for Women & You

PAYROLL DEDUCTIONS

Payroll deductions for the medical, dental and vision plan options effective 1/1/2022 - 12/31/2022:

Employee Cost Per Pay Period
MEDICAL COVERAGE WITH DC HEALTH LINK
ALL CAREFIRST PLAN OPTIONS The medical premiums are age banded. Each employee will have a different premium based on your age and based on the dependents age. **CAREFIRST REFERENCE PLAN OPTION (BLUE CHOICE ADVANTAGE POS 1500 GOLD HSA PLAN)** Women for Women pays 100% of the employee only premium and 80% of the cost for dependents for the Reference plan regardless of your age.

Employee Cost Per Pay Period			
DENTAL & VISION	**DENTAL CORE PLAN**	**DENTAL BUY-UP PLAN**	**VISION PLAN**
Employee Only	$6.05	$16.83	$1.17
Employee + Spouse (or Domestic Partner)	$12.76	$27.66	$2.22
Employee + Child(ren)	$21.82	$36.54	$2.60
Employee + Family	$32.96	$57.02	$3.66

HEALTH CARE PLAN INFORMATION

IN-NETWORK ADVANTAGE

Consider your health care options highlighted in this guide. The Choice Plus HSA plan is the only plan that gives you the freedom to use any healthcare provider of your choice. However, when you use an in-network provider, the percentage you pay out-of-pocket will be based on a negotiated fee, which is usually lower than the actual charges. If you use a provider who is outside of the network, you may be responsible for paying the difference between your insurance carrier's allowable charges and what the provider charges. This is called balance billing. Allowable charges are set by the insurance carrier and are the amounts that are generally considered reasonable based on what most providers charge for a particular service in a geographic area.

COPAYMENTS AND COINSURANCE

A **copayment** (copay) is the fixed dollar amount you pay for certain in-network services. In some cases, you may be responsible for the deductible or coinsurance after the copay is made.

Coinsurance is the percentage of covered expenses shared by the employee and the plan. For example, if you pay 20% of an in-network covered charge, the plan pays 80%. In some cases, coinsurance is paid after the insured meets a deductible.

ANNUAL DEDUCTIBLE

Your annual **deductible** is the amount of money you must first pay before your plan begins paying for services covered by coinsurance. Some services, such as office visits, may require copays and may not apply to the deductible. Your annual medical deductible is on a calendar year basis. The dental deductible is also on a calendar year basis.

After you meet your deductible, the plan pays for a percentage of eligible expenses (coinsurance) until you meet your out-of-pocket maximum. If you receive services from an out-of-network provider, you may have a larger deductible and the plan may pay a lower percentage of coinsurance. Refer to your health care plan summaries for more information.

OUT-OF-POCKET MAXIMUM

Some plans feature an **out-of-pocket** maximum, which limits the amount you will pay for eligible health care expenses. Once you reach that maximum, the plan begins to pay 100% of eligible expenses. There may be separate in- and out-of-network out-of-pocket maximums. All copays, deductibles and coinsurance accrue to the out-of-pocket maximums. Your out-of-pocket maximum is on a calendar year basis.

Medical Benefits: Preventive Care Services

Preventive care is covered in-network at 100% (no deductible or copay) for those services that are generally linked to designated routine wellness exams and screenings. Examples of preventive care services include:

- Annual routine physicals, immunizations (subject to age frequency / limitations)
- Cholesterol screening
- Mammograms, pap smears, pelvic exams
- PSA (Prostate Specific Antigen) exams

There may be limits on how often you can receive preventive care treatments and services. You should ask your health care provider whether your visit is considered preventive or non-preventive care. Please refer to https://www.healthcare.gov/coverage/preventive-care-benefits/ for a list of eligible preventive services.

MEDICAL BENEFITS

CAREFIRST / DC HEALTH LINK
DCHEALTHLINK.COM

Your medical coverage will be provided by CareFirst through the DC Health Exchange also known as the DC Health Link. Women For Women will offer all the Carefirst plans available, you have the choice to pick the best option to meet your needs.

The information below is a brief summary of the reference plan/ core plan, **Blue Choice Advantage POS HSA Gold $1,500** medical coverage only. Please contact CareFirst or Human Resources for plan summaries detailing coverage information, limitations, and exclusions. Any deductibles, copays, and coinsurance percentages shown in the chart below are amounts for which you are responsible.

Blue Choice Advantage POS HSA Gold $1,500	
KEY FEATURES	**IN-NETWORK**
Calendar Year Deductible	$1,500 Individual / $3,000 Family
Calendar Year Out-of-Pocket Maximum	$3,200 Individual / $6,400 Family
Coinsurance (Member / CareFirst)	Copayments / 100%
Primary Care Physician (PCP) Office Copay	$10 copay after deductible
Specialist Office Copay	$20 copay after deductible
Lab Test & X-Rays	$20 copay after deductible
Complex Imaging (MRI, CAT Scans, etc.)	$50 / $100 copay after deductible
Inpatient Hospital - Facility Fee	$200 copay per admission after deductible
Urgent Care	$50 copay after deductible
Emergency Room (copay waived if admitted)	$100 copay after deductible
	OUT-OF-NETWORK
Calendar Year Deductible	$3,000 Individual / $6,000 Family
Calendar Year Out-of-Pocket Maximum	$6,400 Individual / $12,800 Family
Coinsurance (Member / CareFirst)	Copayments / 100%
IN-NETWORK PRESCRIPTION DRUG	
Prescription Drug Deductible	Integrated with medical deductible. Must meet medical deductible **first**, then:
Retail: Up to a 30-day supply	Tier 1: $10 copay / Tier 2: $45 copay / Tier 3: $65 copay
Mail Order: Up to a 90-day supply	Tier 1: $10 copay / Tier 2: $45 copay / Tier 3: $65 copay

MEDICAL BENEFITS

CAREFIRST / DC HEALTH LINK

DCHEALTHLINK.COM

AGGREGATE DEDUCTIBLE

REFERENCE PLAN: BLUE CHOICE ADVANTAGE POS HSA GOLD $1,500 HAS A AGGREGATE DEDUCTIBLE

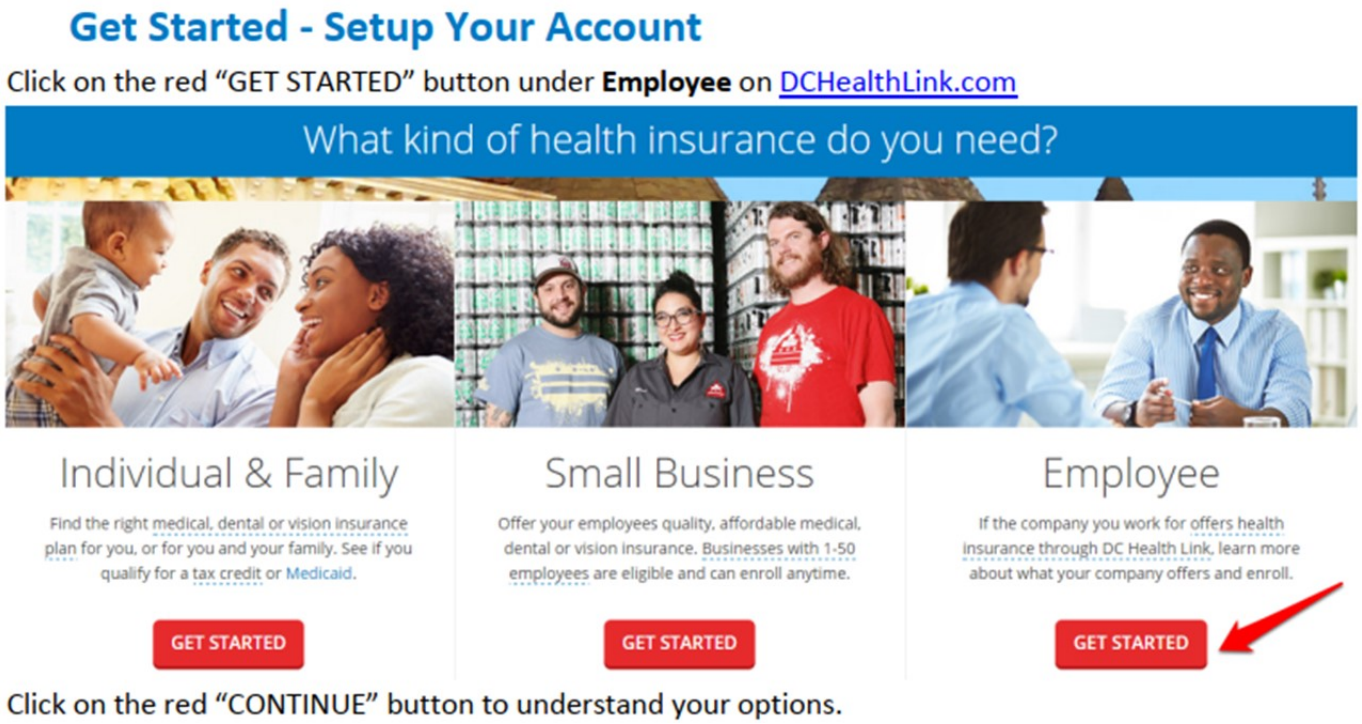
With the Reference Plan High Deductible Health Plan if you have any dependents enrolled in the plan then the family deductible must be met before any member would receive benefits. So, if you are enrolled as an individual or employee only in the High Deductible Health Plan then the deductible is $1,500. However, if you are enrolled in the High Deductible Health Plan with any dependents like a spouse or children then the $3,000 family deductible must be met even for just one member before any benefits are covered.

Also, with the High Deductible Health Plan the prescription drugs will apply to the deductible before any copayments apply.

	IN-NETWORK DEDUCTIBLE ON REFERENCE PLAN
Enrolled as Employee Only	$1,500
Enrolled as Employee & Spouse, Employee & Children or Employee & Family	$3,000

DC HEALTH LINK

All employees must go into the DC Health Link and enroll to select coverage or waive coverage!



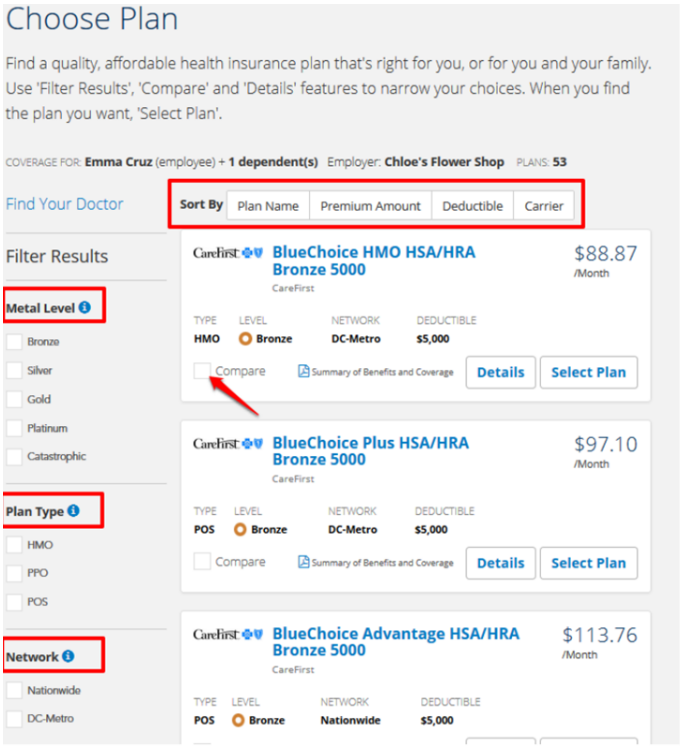
MEDICAL BENEFITS

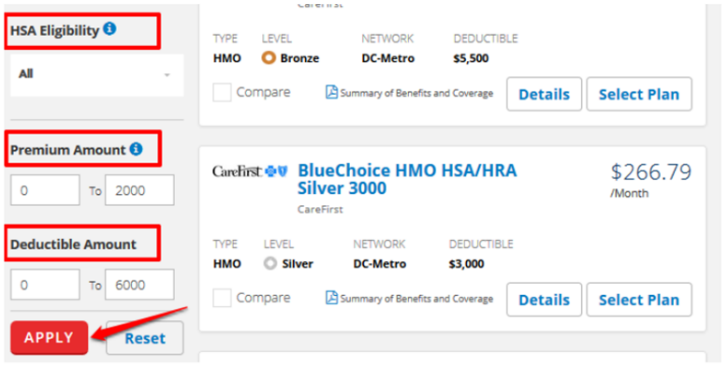
CAREFIRST / DC HEALTH LINK

DCHEALTHLINK.COM

DC HEALTH LINK

All plans offered by Women for Women are listed on this page. You do not have to pick the reference plan, you can select any of the CareFirst plans. You are able to sort plans by a variety factors: Metal level, plan type, network, HSA eligibility, premium amount, and deductible amount. Select "Apply" in the red box at the bottom of the column on the left side to apply the selected filters. More information can be found about each plan by selecting "Details" on each plan offered.





Be sure to fill out your email address and create a password (8 character minimum) and then click the "Create account" button. Please be sure to record your password somewhere secure. You'll use your email address as your login in the future.

HEALTH SAVINGS ACCOUNT (HSA)

ISOLVED

1.800.300.3838 | ISOLVEDBENEFITSERVICES.COM

Take charge of your healthcare spending with a health savings account (HSA) which works alongside the qualified Blue Choice Advantage POS HSA Gold $1,500. An HSA is a personal healthcare bank account that you can use to pay out-of-pocket medical expenses with pre-tax dollars.

The contributions made to your HSA are tax-free, and the money remains in the account for you to spend on eligible expenses, no matter where you work or how long it stays in the account. HSAs allow you to control your own money, year in and year out. You have the option of filing claims through your HSA portal or using your debit card which is provided by Optum Bank once you enroll in the HSA Plan.

You are eligible to open and fund an HSA if:

- You are covered by an HSA-eligible high deductible health plan
- You are not covered by your spouse's healthcare flexible spending account (FSA) or health reimbursement arrangement (HRA)
- You are not eligible to be claimed as a dependent on someone else's tax return
- You are not enrolled in Medicare or TRICARE
- You are not receiving Social Security benefits
- You have not received Veterans Administration benefits in the last three months

Your HSA account can be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP. Eligible expenses include doctor's office visits, eye exams, prescription expenses, and LASIK surgery. IRS Publication 502 provides a complete list of eligible expenses and can be found at www.irs.gov.

INDIVIDUALLY OWNED ACCOUNT

You own your HSA. You determine how much you will contribute to your account, when to use the funds to pay for eligible medical expenses, and when to reimburse yourself. Like a bank account, you must have a balance in order to be reimbursed. Although receipts are not required for reimbursement, we recommend that you keep receipts for tax documentation. HSAs allow you to save and "roll over" funds if you do not spend the funds within the calendar year. The funds in this account are always yours, even if you change health plans or jobs. There are no vesting requirements or forfeiture provisions.

MAXIMIZE YOUR TAX SAVINGS*

Contributions to an HSA are tax-free; they can be made through payroll deduction on a pre-tax basis when you open an account with HealthCare Bank. If your HSA is with another financial institution, you can make after-tax contributions and take the tax credit at the end of the year when you file your taxes.

- The money in this account (including interest and investment earnings) grows tax-free
- As long as the funds and any earnings are used to pay for qualified medical expenses, they are spent tax-free

**HSA contributions and earnings are not subject to federal taxes and not subject to state taxes in most states. Please consult your personal tax advisor or contact your plan administrator for information about your state.*

HSA FUNDING AND LIMITS

The 2022 IRS maximum contributions, including employer contributions for these accounts, are:

Single coverage - $3,650 **Dependent coverage - $7,300**

The Women for Women contributions for these accounts are: **$1,000 for Individual and $2,000 for Family coverage**

Note: Individuals age 55 and older may make an additional annual contribution of $1,000.
Please note that the maximum contribution includes both employer and employee HSA contributions and is pro-rated for the number of months you are eligible for an HSA. Your contributions can be changed at any time throughout the year. Please reach out to Human Resources with any questions.

DENTAL BENEFITS

AMERITAS

1.800.487.5553 | WWW.AMERITASGROUP.COM

Dental coverage is a key component of your overall health and wellness. Women for Women International offers two dental plans through Ameritas which covers four main types of expenses:

- **Preventive and Diagnostic Services**: routine exams and cleanings, fluoride treatments (through age 18), sealants (through age 15), and X-rays
- **Basic Services**: simple fillings and extractions, root canals, oral surgery, and gum disease treatment
- **Major Services**: crowns, bridgework and dentures
- **Orthodontia**: Included for adults and children

	Core Plan
KEY FEATURES	**IN-NETWORK ONLY**
Calendar Year Maximum (per member)	$1,500
Calendar Year Deductible - Individual / Family	$50 / $150
Preventive Services (deductible does not apply)	100%
Basic Services	80%
Major Services	50%
Orthodontia Coverage (adults and children)	50%
Orthodontia Lifetime Max	$1,000 per adult or child

	Buy-Up Plan	
KEY FEATURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Calendar Year Maximum (per member)	$2,000	$1,500
Calendar Year Deductible - Individual / Family	$50 / $150	
Preventive Services (deductible does not apply)	100%	100%
Basic Services	90%	80%
Major Services	60%	50%
Orthodontia Coverage (adults and children)	50%	50%
Orthodontia Lifetime Max	$1,000 per adult or child	

REWARDS ROLL OVER PROVISION

Ameritas members can carry over a portion of unused annual maximum to be used the next year. The member must have at least one submitted claim during the benefit period to take advantage of Roll Over benefit. Claims paid during the benefit period must be less than the benefit threshold amount. If a member doesn't submit a dental claim during a benefit year, all accumulated rewards are lost.

Benefit Threshold: $750 | Annual Carry Over Amount: $250 | Maximum Carryover: $1,000

VISION BENEFITS

UNITEDHEALTHCARE

1.800.638.3120 | WWW.MYUHCVISION.COM

Women for Women International offers you access to vision coverage through UnitedHealthcare. The plan frequency is every 12 months for exams, lenses, and frames.

	Plan V1048	
KEY FEATURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Eye Exam	$15 copay	Up to $40 allowance
Frames	$130 allowance & 30% off balance over $130	Up to $45 allowance
Lenses	**Single / Bifocal / Trifocal:** $30 copay	**Single / Bifocal / Trifocal:** Up to $40 / Up to $60 / Up to $80
Contact Lenses Elective Contact Lenses Medically Necessary	 $130 allowance No charge after copay (if applicable)	 Up to $105 allowance Up to $210 allowance

Note: Contact lenses are in lieu of frames and/or eyeglass lenses. UnitedHealthcare has partnered with QualSight LASIK, the largest LASIK manager in the United States, to provide our members with access to discounted laser vision correction providers. Member savings represent up to 35% off the national average price of Traditional LASIK. Contracted prices start at $945 per eye for Traditional LASIK and $1,395 per eye for Custom LASIK. Discounts are also provided on newer technologies such as Custom Bladeless (all laser) LASIK. For more information, visit myuhcvision.com.

A visit with your eye doctor can determine whether you need corrective lenses and, if so, the correct prescription. Other eye concerns that will be addressed in an eye exam include checking for conditions or diseases such as glaucoma and cataracts, which can lead to vision loss.

Regular eye exams can also identify overall health concerns, such as diabetes, high cholesterol and risk of heart disease or stroke before you are even aware of any symptoms. You can then follow up with a medical doctor, minimizing the effects of these conditions on your health and finances.

INCOME PROTECTION

LINCOLN

1.800.423.2765 | WWW.LFG.COM

BASIC LIFE AND AD&D INSURANCE | LINCOLN

Women for Women International provides you with basic life insurance and accidental death and dismemberment (AD&D) coverage administered by Lincoln with a benefit of one times your annual salary up to a maximum of $150,000 for basic life and AD&D. The benefit reduction schedule for basic life is 33% at age 65 and an additional 22% at age 70.

LONG-TERM DISABILITY | LINCOLN

Women for Women International provides a long term disability plan that pays 60% of your monthly covered earnings, up to a maximum benefit of $5,000 per month. Benefits begin after 90 consecutive days of disability. Benefits continue through Social Security Normal Retirement Age (SSNRA) or a schedule depending on your age at the time you're disabled. You also have the tax choice of having this benefit pre or post tax.

401(K) | FIDELITY

Women for Women International offers a generous 401(k) retirement savings plan through Fidelity to help you save for your future. You may contribute up to the 2022 IRS limit of $20,500 and an additional catch up contribution of $6,500 if you are over age 50. You may contribute either pre-tax dollars or post-tax dollars via the Roth provision.

You can access your Women for Women retirement account by logging into 401k.com. Here you can set up your participant online account, view or make changes to your investment options, make changes to your contribution rate, designate your beneficiary and much more. To speak to a Fidelity representative please call 1.800.603.4015. As an eligible employee you also have access to our AHT Retirement Services 401(k) advisors at 703.554.6287.

VALUE ADDED SERVICES

TRAVEL ASSISTANCE | LINCOLN FINANCIAL GROUP

This comprehensive worldwide travel assistance program provides pre-trip planning, assistance, and other benefits to covered employees while traveling more than 100 miles from home.

- Pre-Trip info including immunization and visa requirements, weather and cultural information, foreign exchange rates
- Assistance during your travel including but not limited to:
  - -24-hour multilingual interpretation and translation services
  - -Referrals to physicians, dentists, and medical facilities
  - -Address and phone for the nearest American embassy and consulate
  - -Toll-free emergency message relay
  - -Assistance with making emergency travel arrangements
  - -Assistance with lost or stolen items
  - -Finding legal assistance

EMPLOYEE ASSISTANCE PROGRAM (EAP) | LINCOLN FINANCIAL GROUP | COMPSYCH

Women for Women International employees have access to an Employee Assistance Program (EAP) which provides confidential and professional assistance at no cost to eligible employees, their dependents and/or significant others living in the employees' household. Help is available for a variety of health, family and financial issues including stress management, diet and fitness, parenting support, child and elder care, legal issues, will preparation, taxes, and debt management.

Services include:

- Unlimited access to support and helpful resources online
- Consultation with a professional counselor via telephone
- Up to 4 face-to-face counseling sessions for you and your eligible dependents, free of charge
- Free initial 30 minute consultation with an attorney, with a 25% discount on attorney services thereafter
- Unlimited telephonic support for financial problems or planning needs

LIFEKEYS® | LINCOLN FINANCIAL GROUP | COMPSYCH

Women for Women International employees can take advantage of LifeKeys® services from Lincoln Financial Group which include online will preparation; information on important life matters including legal, financial, family and career; protection against identity theft; and guidance and support for our beneficiaries such as grief counseling, financial and legal advice, and coping with the occasional challenges of day-to-day life.

MOTHER'S ROOM

Fully equipped, thoughtfully appointed private space

Features:

- Refrigerator storage
- Fully equipped sink
- Storage space
- Light dimmer
- Lotions and towels
- Bottle/pouch warmers

Located in the Fitness Center, Lower Level

ADDITIONAL BENEFITS

FLEXIBLE SPENDING ACCOUNTS
ISOLVED | 1.800.300.3838 | ISOLVEDBENEFITSERVICES.COM

Flexible Spending Accounts (FSAs) help you save money by allowing you to pay for certain types of healthcare and dependent care expenses on a pre-tax basis. You decide how much money to put aside annually in one or both FSAs. The plan year is January 1, 2022 - December 31, 2022. Note: You will be able to rollover up to $500 in unused funds from your Healthcare FSA into the next plan year.

ACCOUNT	2022 CONTRIBUTIONS / LIMITS
General Purpose Healthcare FSA **Not eligible if enrolled in the HSA*	$2,850 maximum (allows $500 roll-over of unused balances at year end)
Limited Purpose Healthcare FSA **Only eligible if enrolled in the HSA*	$2,850 maximum
Dependent Care FSA	$5,000 maximum ($2,500 if married and filing separately)

To be eligible to participate, you do not need to be enrolled in the Medical Carrier medical plans, but you do need to remain enrolled in the FSA plan for the full 12 months. No mid-year changes are permitted without a qualifying event.

Eligible healthcare expenses may include:

- Office visit & prescription drug co-payments
- Deductibles & Co-insurance
- Expenses not covered under your plan
- Out-of-pocket dental, vision, or hearing related expenses

The plan and process works like this:

- You elect to participate in either or both the healthcare or dependent care Flexible Spending plan.
- Through payroll deduction, you begin setting pre-tax dollars aside based on your annual election.
- The annual amount is deducted evenly from each pay period (24) and deposited into your FSA.
- You incur an expense and file a claim that qualifies for reimbursement.

Dependent Care Account

The Dependent Care Flexible Spending plan is designed to help you save money on the child care expenses you and your spouse incur during the year. Child care expenses may include day care, nursery school costs, or after-school programs. This plan can also be used for expenses incurred in the care of elderly parents, a disabled spouse or a disabled child.

ADDITIONAL BENEFITS

FLEXIBLE SPENDING ACCOUNTS (CONTINUED)

Dependent Care Account (continued)
Please note, the Dependent Care Flexible Spending Account is not for dependent medical expenses; this account is specifically for the care of your child or dependent while you and/or your spouse are at work or attending school. Note that certain conditions must be met for eligibility. Please visit the iSolved website, which has a great resource center, or see HR for more details on eligibility requirements.

Limited-Purpose Healthcare Account
A Limited-Purpose FSA is much like a typical, general purpose health FSA. However, under a limited-purpose FSA, eligible expenses are limited to qualifying dental and vision expenses for you, your spouse, and your eligible dependents.

Limited-Purpose FSA Plans are designed for employees that are also contributing to a Health Savings Account and are not eligible for a general purpose health FSA plan — you are only eligible if you are enrolled in a Health Savings Account. By participating in this plan you are able to save money on expenses you are already paying for like dental checkups, vision exams, eyeglasses, and much more. Funds are available on the first day. Please reach out to HR for more details on the Limited-Purpose FSA Plan option.

PARKING AND TRANSIT EXPENSE PLANS

The Parking and Transit Expense Plans are IRS approved plans under Section 132 of the Internal Revenue Code. These plans allow participants to contribute money through payroll deductions on a pre-tax basis. The money that is set aside is then used to pay for work-related parking, commuting and van-pool expenses.

ACCOUNT	2022 CONTRIBUTIONS / LIMITS
Transit Account	$280 per month (Women for Women contributes $40 through WMATA Smart Benefits)
Parking Account	$280 per month (Women for Women contributes $40 through LAZ Parking)

Eligible Expenses:

- Parking: Expenses incurred to park your car at or near work
- Transit: Expenses incurred for pass, token, farecard, voucher or similar item used for a mass-transit system in order to commute to work

Ineligible Expenses:

- Non-work related transit or parking expenses
- Tolls, gas, or other driving related expenses
- Expenses incurred traveling from your office to business or client meetings
- Transit or parking expenses incurred by your spouse and/or dependents

IMPORTANT LEGAL NOTICES FROM WOMEN FOR WOMEN INTERNATIONAL

EMPLOYEE HEALTH CARE PLAN NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment)
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP)

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Human Resources
2000 M Street NW Suite 200
Washington D.C. 20036
202.737.7705

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women for Women International Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 of the mastectomy, including lymphedemas

The Women for Women International Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator.

MATERNITY NEWBORN AND INFANT COVERAGE

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarian section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A qualified medical child support order (QMCSO) is a judgment from a state court or an order issued through an administrative process under state law that requires you to provide coverage for a dependent child under the Women for Women International health care plans. You may obtain a copy of the QMCSO administrative procedures, free of charge, from the Plan Administrator. In any case, if you are subject to an order, you and each child will be notified about the procedures.

CREDITABLE COVERAGE NOTICE: YOUR WOMEN FOR WOMEN INTERNATIONAL 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 Women for Women International and your options under Medicare's prescription drug coverage (if you are eligible for Medicare). This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like a 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 better coverage for a higher monthly premium.

2. Women for Women International has determined that the prescription drug coverage offered under the group health care plans under Women for Women International Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Because your existing coverage is Creditable Coverage, you can keep it 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 15 through December 7. However, if you lose your current creditable coverage, through no fault of your own, you will also be eligible for a two 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 Women for Women International coverage will not be affected. If you drop your coverage with Women for Women International and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of Medicare prescription drug coverage in your area.

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 Women for Women International and don't join a Medicare drug plan within 63 continuous days after you 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 19 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 November to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

To obtain more information about this notice or your current prescription drug coverage, contact Human Resources. You'll get this notice each year. You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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 www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the Medicare-approved plans offering prescription drug coverage, you may need to provide a copy of this notice when applying for the coverage to show that you are not required to pay a higher premium amount.

Date: January 1, 2022
Sender: Women for Women International
Contact: Human Resources
Address: 2000 M Street NW
Suite 200
Washington DC 20036
Phone: 1.202.737.7705

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What Is "Balance Billing" (Sometimes Called "Surprise Billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You Are Protected From Balance Billing For:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain Services at an In-network Hospital or Ambulatory Surgical Center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

What When Balance Billing Isn't Allowed, You Also Have the Following Protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.
    -

Visit https://www.federalregister.gov/ for more information about your rights under federal law.

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, 2022. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website: https://www.dhcs.ca.gov/hipp
Phone: 1-916-445-8322
Fax: 916.440.5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party liability/childrens-health-insurance-program reauthorization- act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid

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)

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/hip
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: http://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
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

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840

MINNESOTA – 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

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000 | Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid AND CHIP
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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA—Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA—Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS—Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440.0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
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
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING - Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

FOR MORE INFORMATION

Use the chart below to learn more about your Women for Women International benefits. The carriers' websites and toll-free customer service numbers are a valuable resource when utilizing and reviewing the benefits available to you.

BENEFIT	REASONS TO CALL	WHO TO CALL	PHONE NUMBER	WEBSITE/EMAIL
Women for Women International Human Resources	**HR questions**	**Ovuoke Ubogu**	**1.202.449.4985**	**oubogu@womenforwomen.org**
Medical	Claims, Benefits, Find a provider	CareFirst/DC Health Link		DCHealthLink.com
Dental	Claims, Benefits, Find a provider	Ameritas	1.800.487.5553	www.ameritasgroup.com
Vision	Claims, Benefits, Find a provider	UnitedHealthcare	1.800.638.3120	www.myuhcvision.com
Life, AD&D, and Disability	Claims, Benefits	Lincoln	1.800.423.2765	www.lfg.com
Employee Assistance Program (EAP)	Counseling	ComPsych	1.888.628.4824	www.guidanceresources.com Username: LFGsupport Password: LFGsupport1
LifeKeys	Financial and legal questions	ComPsych	1.855.891.3684	Web ID: LifeKeys
Travel Assistance	Trip services	Lincoln	U.S & Canada: 1.866.525.1955 Intl: 1.603.328.1955	www.mysearchlightportal.com Group ID: LFGTravel123
FSA	Claims and account information	iSolved	1.800.300.3838	Isolvedbenefitservices.com
HSA	Claims and account information	iSolved	1.800.300.3838	Isolvedbenefitservices.com
401k	Retirement questions	Fidelity	1.800.603.4015	www.fidelity.com