NOAH
Neighborhood Outreach Access to Health

2022

Benefits Information Guide

Employees

Hello!

Welcome to your 2022 Benefits Plan Year. Neighborhood Outreach Access to Health is proud to offer a range of employee benefit plans to help protect you in the case of illness or injury. This Benefits Information Guide is a comprehensive tool designed to familiarize you with the plans and programs you and your family can enroll in for the plan year. If you have any questions regarding your benefits, please contact Human Resources.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 2 months, Federal law gives you more choices about your prescription drug coverage. Please see page 32 for more details.

Eligibility & Enrollment

Who can Enroll?

If you are an employee regularly working a minimum of 20 hours per week, you are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/registered domestic partner (as legally defined under state and local law) (hereinafter referred to as "registered domestic partner and/or eligible children.

An employee may be unable to pay for and/or receive employer contributions on a pre-tax basis for the cost of the benefits of an employee's state registered / unregistered domestic partner that does not meet the definition of the employee's tax dependent under IRC Section 152.

When Does Coverage Begin?

Regular, full-time employees: You are eligible for all benefits on the first of the month following your date of hire, except Life, Disability, and Worksite benefits. Life, Disability and Worksite benefits are effective the first of the month following 90 days from your date of hire.

Regular, part-time employees: Employees regularly working 20-29 hours are eligible to enroll on the first of the month following your date of hire for all benefits except Employer Paid Life and Disability. Voluntary Life and Worksite benefits are effective the first of the month following 90 days from your date of hire.

Variable hourly employees: You are eligible to enroll at the end of your Measurement Period (initial or standard), if you successfully average 30 or more hours of service per week during that time period. Your coverage will be effective 30 days following the date you are eligible to enroll in coverage.

Your enrollment choices remain in effect through the end of the benefits plan year, January 1, 2022 – December 31, 2022.

TIP

If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status during the plan year. Please review details on IRS qualified change in status events for more information.

How do I Enroll?

Paycom

Paycom will send an email to all employees with the enrollment instructions on how to enroll in your 2022 employee benefits.

What if My Needs Change During the Year?

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the qualified event. Change in status examples include:

- Marriage, divorce, or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse/registered domestic partner's loss or gain of coverage through our organization or another employer.
- An employee (1) is expected to average at least 20 hours of service per week, (2) has a change in status where he/she will reasonably be expected to average less than 20 hours of service per week (even if he/she remains eligible to be enrolled in the plan); and (3) intends to enroll in another plan that provides Minimum Essential Coverage (no later than the first day of the second month following the month of revocation of coverage).
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange and it are effective no later than the day immediately following the revocation of your employer-sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare, or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of qualified status changes, please refer to the "Legal Information Regarding Your Plans" contents.

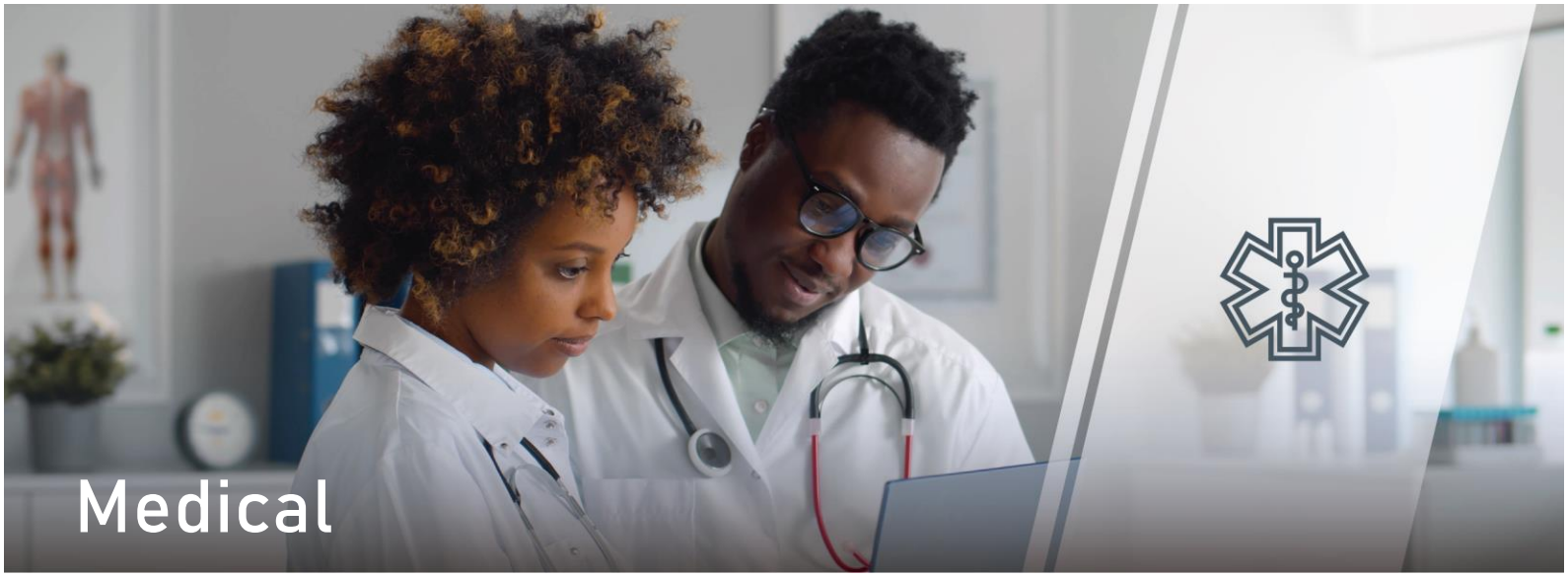
Do I Have to Enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, some states have their own state-specific individual mandates.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as coverage from a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform and the Individual Mandate, please contact Human Resources or visit www.cciio.cms.gov.

You may elect to "waive" medical/dental/and/or vision coverage if you have access to coverage through another plan. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be on January 1, 2023 or if a qualifying status, change occurs.



What are my options?

Use the chart below to compare medical plan options and determine which would be the best for you and your family.

	PPO	HDHP
	Ameriben	**Ameriben**
Required to select and use a Primary Care Physician (PCP)	No	No
Seeing a Specialist	No referral required	No referral required
Deductible Required	Yes, in most cases Embedded: Yes	Yes Embedded: Yes
Claims Process	PPO network providers will submit claims. You may have to submit claims for out of network provider services	PPO network providers will submit claims. You may have to submit claims for out of network provider services
Compatible with your Health Savings Account (HSA)	No, unless PPO is also a HDHP	Yes
Other Important Tips	• You may choose in or out-of-network care, however in-network care provides you a higher level of benefit. • Emergencies covered worldwide. • Out-of-network providers will bill the balance to the member for amounts not covered by Ameriben.	• You may choose in or out-of-network care, however in-network care provides you a higher level of benefit. • Emergencies covered worldwide. • Out-of-network providers will bill the balance to the member for amounts not covered by Ameriben • Although this plan has a higher deductible than most plans, it may offer lower payroll deductions. • The HSA account provides a tax-favored vehicle to help you manage your out-of-pocket expenses.

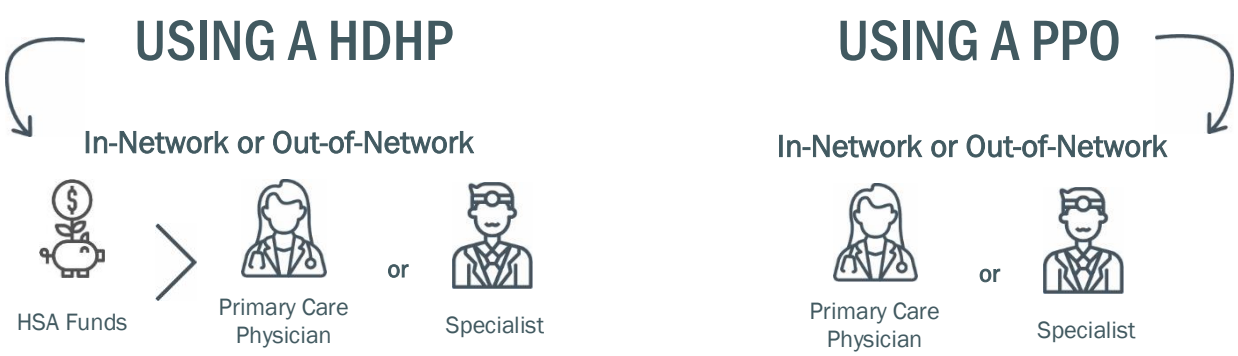
Please note the above examples are used for general illustrative purposes only. Please consult with your Human Resources department for more specific information as it relates to your specific plan. For a detailed view of your medical plan summaries, please download the iNGAGED Benefit App and use **Company Code: NOAH** . Your enrollment resource will be available by 10/12/2021.

TIP

Medical Services Covered in Full

The federal Health Care Reform law now requires insurance companies to cover preventive care services in full; saving you money and helping you maintain your health. Preventive services may include annual check-ups, well-baby and child visits and certain immunizations and screenings.

To confirm that your preventive care services are covered, refer to your plan documents.



Plan Highlights	Coordinated Care Plan		Standard Plan	
	NOAH /Innovation Care Partners Network/Honor Health Facilities	**BlueCross BlueShield of AZ**	**NOAH /Innovation Care Partners Network/Honor Health Facilities**	**BlueCross BlueShield of AZ**
Annual Calendar Year Deductible				
Individual	$500		$500	
Family	$1,000		$1,000	
Maximum Out-of-pocket (1)				
Individual	$5,000		$6,450	
Family	$10,000		$12,900	
Professional Services				
Primary Care Physician (PCP)	$20 copay	Not Covered	$20 copay	$40 copay
Specialist	$50 copay	Not Covered	$60 copay	$125 copay[1]
Telehealth Visit	$20 copay	$20 copay	$20 copay	$20 copay
Preventive Care Exam	Plan Pays 100%	Not covered	Plan Pays 100%	Not covered
Diagnostic Laboratory Service X-ray, Ultrasound	$10 copay $10 copay	$10 copay 50%	$15 copay, deductible waived	Lab: $15 copay 25%, deductible waived X-ray: 25%, deductible waived
Complex Diagnostics (MRI/CT Scan)	$150 copay	Not covered	$200 copay	$200 copay, then 50%
Alternative Care e.g., Chiropractic & Acupuncture, refer to Plan Document for full list of services.	75% up to $1,000, then Plan pays 10% All services combined		75% up to $1,000, then Plan pays 10% All services combined	
Hospital Services				
Inpatient	20% after ded	Not covered	15% after ded	50% after ded
Outpatient Surgery	20% after ded	Not covered	15% after ded	50% after ded
Urgent Care	$35 copay	$60 copay	$35 copay	$60 copay
Emergency Room	$250 copay		$300 copay	
Mental Health & Substance Abuse				
Inpatient	20% after ded		15% after ded	
Outpatient	$20 copay		$20 copay	
Retail 30-Day Prescription				
ACA Preventative Maintenance Medications	No charge, deductible waived		No charge, deductible waived	
Tier 1 – Retail Generic	$10 copay, deductible waived		$15 copay, deductible waived	
Tier 2 – Retail Preferred	30% ($30 min up to $80 max)		35% ($40 min up to $100 max)	
Tier 3 – Retail Non Preferred	60% ($100 min, no max)		60% ($125 min, no max)	
Retail 90 day Prescription Drugs				
Tier 1 – Retail 90 Generic	$25 copay, deductible waived		$37.50 copay	
Tier 2 – Retail Preferred	30% ($75 min up to $200 max)		35% ($100 min up to $250 max)	
Tier 3 – Retail Non Preferred	100%, deductible waived		100%, deductible waived	
Mail Order 90-Day Prescription Drugs				
ACA Preventative Maintenance Medications	No charge, deductible waived		No charge, deductible waived	
Tier 1 – Mail Order Generic	$25 copay, deductible waived		$37.50 copay, deductible waived	
Tier 2 – Mail Order Preferred	30% ($75 min up to $200 max)		35% ($100 min up to $250 max)	
Tier 3 – Mail Order Non Preferred	Not Covered		Not Covered	
Specialty Drugs				
	30% ($50 min up to $100 max)		30% ($60 min up to $150 max)	

[1]Member will pay $60 copay if specialty not in Tier 1; If specialty in Tier 1, member will pay $125 copay

Plan Highlights

Health Savings Account Plan (HDHP)

	NOAH /Innovation Care Partners Network/Honor Health Facilities	BlueCross BlueShield of AZ
Annual Calendar Year Deductible		
Individual	$2,800	
Family	$5,600	
Maximum Out-of-pocket [1]		
Individual	$6,450	
Family	$12,900	
Professional Services		
Primary Care Physician (PCP)	10% after deductible	20% after deductible
Specialist	10% after deductible	20% after deductible
Telehealth Visit	10% after deductible	20% after deductible
Preventive Care Exam	0% after deductible	0% after deductible
Diagnostic X-ray and Lab	10% after deductible	20% after deductible
Complex Diagnostics (MRI/CT Scan)	10% after deductible	20% after deductible
Alternative Care e.g., Chiropractic & Acupuncture, refer to Plan Document for full list of services.	75% after deductible up to #1,000 then Plan pays 10%. All Services combined	
Hospital Services		
Inpatient	10% after deductible	20% after deductible
Outpatient Surgery	10% after deductible	20% after deductible
Urgent Care	20% after deductible	20% after deductible
Emergency Room	20% after deductible	
Mental Health & Substance Abuse		
Inpatient	10% after deductible	50% after deductible
Outpatient	10% after deductible	50% after deductible
Retail 30-Day Prescription		
ACA Preventive Maintenance Medications	$0 copay, deductible waived	
Tier 1 – Retail Generic	$15 copay after deductible	
Tier 2 – Retail Preferred	35% ($40 min up to $100 max) after deductible	
Tier 3 – Retail Non Preferred	60% ($125 min, no max) after deductible	
Retail 90-Day Prescription		
Tier 1 – Retail 90 Generic	$37.50 copay after deductible	
Tier 2 – Retail Preferred	$35% ($100 min up to $250 max) after deductible	
Tier 3 – Retail Non Preferred	100%, after the deductible	
Mail Order 90-Day Prescription		
ACA Preventive Maintenance Medications	$0 copay, deductible waived	
Tier 1 – Mail Order Generic	$37.50 copay after deductible	
Tier 2 – Mail Order Preferred	$35% ($100 min up to $250 max) after deductible	
Tier 3 – Mail Order Non Preferred	Not Covered	
Specialty Drugs – Lumicera		
	30% ($60 min up to $150 max) after deductible	

Medical Cost Breakdown

The rates below are effective January 1, 2022 – December 31, 2022.

Coverage Level	Payroll Deduction 24 Pays	Payroll Deduction 24 Pays
	Full-Time Employee Semi-monthly	**Part-Time Employee Semi-monthly**
Ameriben - Coordinated Care Plan		
Employee Only	$36.36	$117.42
Employee and Spouse/Registered Domestic Partner	$181.28	$402.73
Employee and Child(ren)	$76.22	$195.70
Employee and Family	$236.90	$510.88
Ameriben - Standard Plan		
Employee Only	$170.98	$385.22
Employee and Spouse/Registered Domestic Partner	$383.16	$799.28
Employee and Child(ren)	$180.25	$403.76
Employee and Family	$470.71	$970.26
Ameriben – High Deductible Plan		
Employee Only	$36.36	$117.42
Employee and Spouse/Registered Domestic Partner	$181.28	$402.73
Employee and Child(ren)	$76.22	$195.70
Employee and Family	$236.90	$510.88

Prescription Drug Coverage

Pharmacy Benefit Manager – Navitus Health Solutions

Many FDA-approved prescription medications are covered through the benefits program. Important information regarding your prescription drug coverage is outlined below:

- The Navitus plan covers generic formulary, brand-name formulary, non-formulary brand, and specialty drugs.
- Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts.
- A brand-name medication is protected by a patent and can only be produced by one specified manufacturer.
- Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list.

NOAH's plan allows participants to purchase a 90-day supply of maintenance medications at retail pharmacies, e.g., Walgreens, CVS, Walmart, etc. You have the option at Retail or Mail Order, the choice is yours!

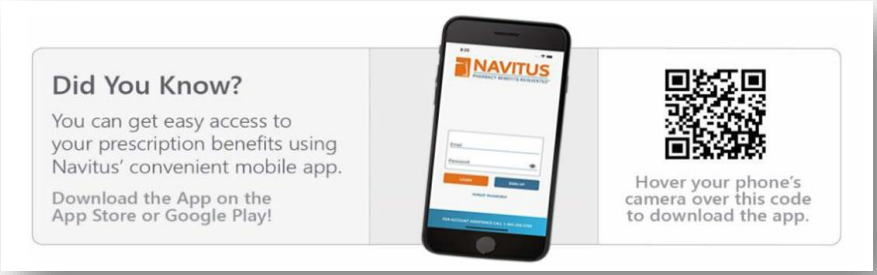
Specialty Medications Pharmacy – Lumicera Health Services

Specialty medications are most often treat chronic or complex conditions and may require special storage or close monitoring. Ordering new prescriptions through our specialty pharmacy partner, Lumicera Health Services is simple. Just call a patient care specialist at 1.855.847.3553 to get started. They will work with you and your prescriber to fill your prescription. The Lumicera team will call and verify your information and review medication details.

Mail Order Pharmacy – Costco Pharmacy

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of a typical 30-day supply at a walk-in pharmacy. It is easy to begin using Costco Pharmacy, register online at pharmacy.costco.com

For a current version of the prescription drug list(s) or get help with your RX benefit questions, go to https://members.navitus.com or call 844-268-9789. Navitus Customer Care is available 24 hours a day, 7 days a week. You do not need to be a Costco member to use Costco Pharmacy.



WHY PAY MORE?

There are a few ways you can save money when using the Prescription Drug Plan:

Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. By calling ahead, you may determine which pharmacy provides the most competitive price.

Explore Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive option that serves the same purpose as prescription medications.

Benefits Information on the Go

iNGAGED

Available for iOS and Android mobile devices, the iNGAGED app makes checking your health and benefits information easier than ever!

- With iNGAGED, you can:
- View our company's benefit plans and resources, 24/7.
- Access policy information and group numbers.
- Quickly contact a benefits carrier.
- Keep up with important benefit plan announcements. Download the "iNGAGED Benefits" app from the App Store or Google Play and use our Company Code NOAH to login to the app. Or, login online at www.ingagedbenefits.com, **Company Code: NOAH**

How to Find a Provider

Neighborhood Outreach Access to Health

Go to: https://noahhelps.org/providers/

Innovation Care Partners (ICP)

Go to: www.innovationcarepartners.com/physiciansearch

Honor Health Facilities

Go to: https://www.honorhealth.com/find-a-location

BlueCross Blue Shield of Arizona Network

1. Go to azblue.com and click "Find a Doctor"
2. From the drop-down choose "Arizona Network"
3. Choose "I am NOT yet a member", and then click on the box that reads "But might get a BCBSAZ health plan through my employer".
4. Click on the arrow next to "Choose a Network".
5. Choose PPO or EPO then click "Search".
6. You are now ready to search for a provider.
7. Call 1.855.961.5370

Telehealth Services

With telehealth, you can connect with leading board-certified physicians for many non-emergency illnesses through the internet or telephone. By leveraging these virtual visits, you can avoid emergency rooms and urgent care centers and quickly refill your prescriptions so you can get back on your feet in no time.

Telehealth can be used for:

General Health Issues

Certain Specialty Services

Prescription

If your telehealth doctor prescribes you medication, TeleDoc will ensure you are able to conveniently pick up your prescription in your local area. You may also use mail-order services for delivery of your prescription.

Simply enroll on www.teladoc.com or download the Teladoc App and register for your account. Once you create an account you will be able to schedule visits with providers and choose your pharmacy should your visit require medication be prescribed.

- **Medical Physicians provide care for a range of common illnesses and injuries.**
- **Counseling Certified psychologists or counselors treat issues affecting emotional, psychological, and social well-being.**
- **Psychiatry Board**-certified psychiatrists provide assessments, evaluations, treatment and prescription support.

What does it cost?

- HDHP members will pay the full amount of the payment until the deductible is met, then the cost share amount will be charged to the member. Medical e-visit $49, Behavioral Health e-visits are based on providers specialty and type of e-visit.
- The applicable plan copay will be applied to members enrolled on the Coordinated Care & Standard Plans accordingly.

How does a telehealth visit work?

Virtual visits are available 24/7/365 and can be conducted anywhere you have access to a smartphone, tablet, or computer with internet access.

Start your eVisit today!

- By Phone: 1-800-835-2362
- Online: www.teladoc.com
- Download TelaDoc's mobile app

TELADOC®

Spending Accounts

Health Savings Account (HSA)

What is it?

By enrolling in the Neighborhood Outreach Access to Health high-deductible health plan, you will have access to a Health Savings Account (HSA), which provides tax advantages and can be used to pay for qualified health care expenses, such as your deductible, copayments, and other out-of-pocket expenses.

What are the benefits?

Administered by Health Equity, an HSA accumulates funds that can be used to pay current and future health care costs.

- You can contribute to your HSA on a pre-tax basis, for federal tax purposes, or you can contribute on a post-tax basis and take the deduction on your tax return.
- Generally, HSA funds can grow on a tax-free basis, subject to state law.[1]
- An HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified health care expenses (tax regulations vary by state).
- Because you own the HSA, there are no “Use it or Lose it” provisions, so unused HSA funds roll over from year-to-year, and can be used to reimburse future eligible out-of-pocket expenses.
- You may enjoy lower monthly premium payments as compared to traditional PPO medical plans.
- Because you own the HSA, the money in your account is yours to keep if you leave the company.
- Neighborhood Outreach Access to Health will match your contributions up to the following amounts:
  - $500 to your HSA for employee-only coverage
  - $1,000 for an employee covering dependents

How do I qualify for an HSA?

The IRS has guidelines regarding who qualifies for an HSA. You are considered eligible if:

- You are covered under a qualified medical plan.
- You are not enrolled in non-qualified health insurance outside of Neighborhood Outreach Access to Health’s HSA PPO plan.
- You are not enrolled in Medicare.
- You are not claimed as a dependent on someone else’s tax return (excluding a spouse).
- You are not enrolled in a general Health Care Flexible Spending Account (Health FSA) or general Health Reimbursement Arrangement (HRA).

* If you are 65 and delay Medicare enrollment, please be aware that when you do apply, Medicare Part A coverage will be retroactive for 6 months. You will need to stop contributing to your HSA six months before Medicare is effective to avoid potential penalties.

** Veterans with a service-connected disability may contribute to an HSA regardless of receiving VA benefits.

How do I get started?

If you are ready to activate your HSA, you can do so by:

- Step 1. Enroll in NOAH's High Deductible Health Plan (HDHP)
- Step 2: Enroll in Health Savings Account with HealthEquity

Once the HSA is activated, you can manage and access your account at any time by visiting or www.healthequity.com. If questions arise regarding account activation, contact HealthEquity at 866-346-5800 or visit www.healthequity.com. Consult your tax advisor for taxation information or advice.

(1) Please consult your tax advisor for applicable tax laws in your state.

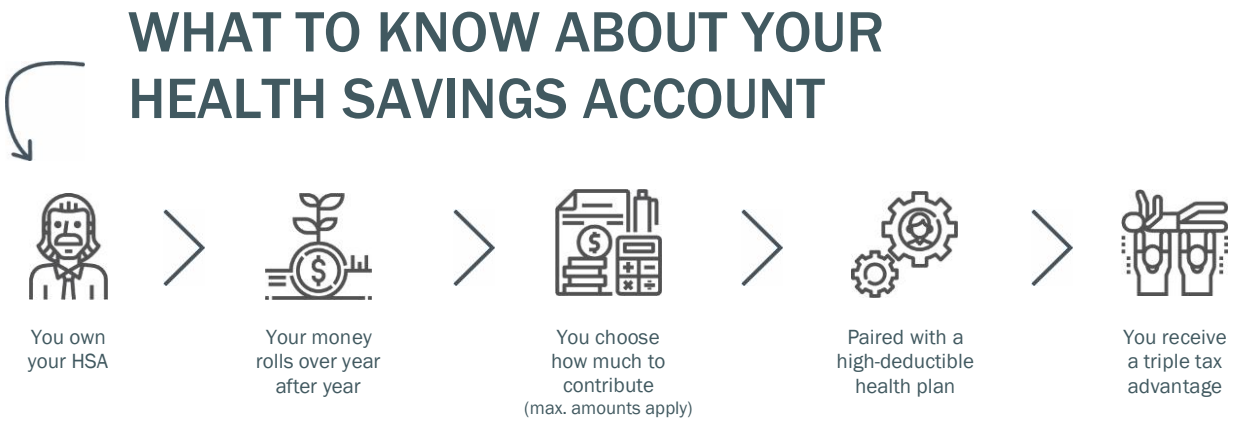
A few rules you need to know:

- For 2022, the maximum contribution limit for employee and employer contributions in an employee's HSA account is $3,650 if you are enrolled in the HSA-PPO for employee-only coverage, and $7,300 for employees with dependent coverage.
- It's important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax.
- There is a 20% penalty for using HSA funds on non-qualified health care expenses if you are under age 65. For more details about what are considered qualified health care expenses, visit www.healthequity.com.
- You may not be able to contribute to your HSA if you are entitled to Medicare. However, funds accumulated before Medicare entitlement may be used to reimburse your qualified medical expenses.
- You may not contribute to your HSA if you are covered under any medical benefits plan, which is not an HSA-qualified high deductible medical plan (e.g., a spouse's non-HDHP medical plan, a general purpose Health Care FSA, or Medicare). However, a Limited Purpose Health Care FSA may cover you, or an FSA, which can be used after your HDHP deductible, is met.
- Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon a **pro-rata** portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would normally be able to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first joins the HSA plan on September 1. However, under the full contribution rule, an employee is allowed to contribute the maximum annual amount, regardless of the number of months he/she was eligible to contribute to an HSA in the first year, if he/she is eligible to contribute to an HSA on December 1 of the first year and continues to be eligible to contribute to an HSA until December 31 of the following year (i.e., for the entire subsequent year).

TIP

How do I manage my HSA?

- **The most convenient way to pay for qualified expenses is to utilize the debit card**
- **You can also use your own cash or a personal credit card and reimburse yourself through your online HSA account**
- **It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS**
- **View the status of your claims and check your HSA balance at www.healthequity.com or call 866-346-5800**



Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible health care and dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
 Health Care FSA	• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance. • Maximum contribution for 2022 is $2,750.
 Limited Purpose FSA	• Option for employees enrolled in a Health Savings Account (HSA) eligible plan. • Use this FSA to reimburse for eligible preventive care, dental and vision expenses. • Maximum contribution for 2022 is $2,750.
 Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) child-care expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Maximum contribution for 2022 is $5,000.

What are the benefits?

- Your taxable income is reduced and your spendable income increases!
- Save money while keeping you and your family healthy.

How do I use it?

You must enroll in the FSA program within 30 days of your hire date or during annual open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. Visit www.wexhealth.com/login to access Wex Health's online portal.

A few rules you need to know:

- You may carryover up to $550 from your 2021 Health FSA to the 2022 plan year
  .

For more details about using an FSA, contact WEX Health at 1-866-451-3399 or visit: https://benefitslogin.discoverybenefits.com/

HOW TO USE YOUR FLEXIBLE SPENDING ACCOUNT

Determine your estimated FSA usage

Set up (pre-tax) deductions from your paycheck

Use FSA debit card or turn in receipts for eligible expenses

Use it or lose it! FSA funds don't roll over to the next year

HOW TO USE YOUR FLEXIBLE SPENDING ACCOUNT

Determine your estimated FSA usage

Set up (pre-tax) deductions from your paycheck

Use FSA debit card or turn in receipts for eligible expenses

$550 of FSA funds can roll over to the next year

Supplemental Health

Critical Illness Coverage

Critical Illness coverage offered on a voluntary basis through The Hartford pays you a lump sum benefit if you are diagnosed with a covered illness or condition. All benefits are paid directly to you and you may use the funds as you see fit.

What can Critical Illness coverage pay for?

- Medical expenses, such as copays, deductibles, or co-insurance.
- Lost Income.
- Everyday expenses such as groceries and utilities.
- Alternative treatments.
- Lodging and travel to a specialist

What are examples of covered illnesses or conditions?

- Cancer.
- Heart Attack.
- Stroke
- Advanced Parkinson's
- Kidney Failure.
- Organ Transplant.

Here's an example of how Critical Illness coverage can help support you

Denise is 45 years old and had a heart attack. She was out of work for a couple of months recovering and although she had disability insurance, it didn't cover all of her lost income and medical bills. Thankfully, Denise had a $10,000 Critical Illness policy. She filed her claim and received her cash benefit so that she could pay her bills and medical expenses. With her Critical Illness policy, Denise had peace of mind and was able to focus on improving her health.

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

100% Employee-paid

If you elect the voluntary Critical Illness plan, 100% of the cost is deducted through payroll deductions.
Monthly rates are per $1,000 of benefit

Benefit options

Election	Benefit Amounts & Guaranteed Issue
Employee	$10,000, $20,000 or $30,000 (Guaranteed issue $20,000)
Spouse	Up to 100% of Employee benefit election (All Guaranteed Issue)
Child(ren)	Children are covered at 50% of employee (All Guaranteed Issue)

Want to learn more? -

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. To learn more or to obtain a full schedule of benefits, please download the iNGAGED Benefit App with **Company Code: NOAH.** Your enrollment resource will be available by 10/12/2021.

Hospital Protection

Planned or unplanned, a trip to the hospital can be unsettling, especially if your primary medical insurance doesn't cover the majority of your costs. Hospital Insurance offered on a voluntary basis through The Hartford pays out cash to you or your family to offset both medical and non-medical bills resulting from a hospital stay.

How can Hospital insurance help?

The cash benefits can be used to pay for services or expenses your traditional medical plan might not cover. Since benefits are paid directly to you, you choose how to use them. Here are a few examples:

- Copayments.
- Deductibles.
- Transportation expenses.
- Child care.
- Lodging expenses for a companion.
- Lost income.

Here's an example of how Hospital Insurance can help support you

Meet Trevor. Trevor had some complications from gallbladder removal surgery, which resulted in a 5-day hospital stay. Through his primary medical insurance, Trevor owed a $500 deductible and $3,000 in co-insurance. With the help of his Hospital Insurance coverage, which paid a $1,000 admission benefit plus $150 for each additional day, he was only out of pocket $1,900 instead of $3,500.

Out-of-Pocket Expenses	Hospital Indemnity Plan Benefits
$500 deductible	$1,000 admission benefit
$3,000 co-insurance	$150/day x 4 additional days = $600
Total: $3,500	**Total benefits paid to Trevor: $1,600**

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

100% Employee-paid

If you elect the voluntary Hospital Insurance plan, 100% of the cost is deducted through payroll deductions. Monthly post-tax rates are outlined below:

Election	Monthly Contribution
Employee Only	$21.65
Employee + Spouse	$36.00
Employee + Child(ren)	$39.58
Family	$56.90

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. To learn more or to obtain a full schedule of benefits, please download the iNGAGED Benefit App with **Company Code: NOAH.** Your enrollment resource will be available by 10/12/2021.

Accident Insurance Plan

Accident Insurance offered on a voluntary basis through The Hartford provides coverage for specific injuries and treatments resulting from a covered accident. The amount of the benefit paid depends on the type of injury and care received.

How can Accident Insurance help?

Since benefits are paid directly to you, you choose how to use them, such as paying medical bills, subsidizing lost income, or covering everyday expenses.

What are some common covered benefits?

- Emergency room visit.
- Ambulance
- Doctor visits.
- Hospital admission.
- Surgery.
- Medical equipment.
- Outpatient therapy.
- Diagnostic imaging.

Covered Event/Injury	Benefit Amount
Ambulance (ground)	$360
Emergency room care	$225
Initial Physician Office Visit 1x per accident within 90 days	$90
X-ray	$50
Concussion	$225
Broken tooth (repaired by crown)	$350
Total benefit paid by Kathy's Accident Plan	**$1,300**

Here's an example of how Accident Insurance can help support you

Kathy's daughter, Molly, plays soccer. During a recent game, she collided with a player, was knocked unconscious and taken to the emergency room (ER) by ambulance. The ER doctor diagnosed a concussion and a broken tooth. He ordered an x-ray scan to check for facial fractures due to swelling. Molly was released to her primary care physician for follow-up treatment and her dentist repaired her broken tooth with a crown. Thanks to Accident Insurance, Kathy will receive $1,100 to help pay for Molly's expenses associated with her accident.

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

100% Employee-paid

If you elect the voluntary Accident Insurance plan, 100% of the cost is deducted through payroll deductions.
Monthly post-tax rates are outlined below:

Election	Monthly Contribution
Employee Only	$8.29
Employee + Spouse	$13.01
Employee + Child(ren)	$14.01
Family	$21.93

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. To learn more or to obtain a full schedule of benefits, please download the iNGAGED Benefit App with **Company Code: NOAH.** Your enrollment resource will be available by 10/12/2021.

Dental Plan

Your Dental PPO Plan

You and your eligible dependents have the opportunity to enroll in a Dental Preferred Provider Organization (PPO) plan offered by Delta Dental.

Using the Plan

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists.

To view a complete plan summary, please download the iNGAGED Benefit App with **Company Code: NOAH.** Your enrollment resources will be available by 10/12/2021.

Plan Highlights	Delta Dental Base Dental PPO		Delta Dental Buy-Up Dental PPO	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Deductible				
Individual	$50		$50	
Family	$150		$150	
Annual Maximum	$1,500		$2,000	
Preventive *(deductible waived)*	0%	20%	0%	20%
Basic Services	20%	50%	20%	50%
Major Services	50%	Not Covered	50%	50%
Orthodontia Services	Not Covered	Not Covered		
Adult	N/A	N/A	50%	
Child up to age 26	N/A	N/A	50%	
Lifetime Maximum	N/A	N/A	$2,500	

The above information is a summary only & based on what the employee pays. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Plan Highlights	Delta Dental Enhanced Dental PPO	
	In-Network	**Out-of-Network**
Calendar Year Deductible		
Individual	$50	
Family	$150	
Annual Maximum	$4,000	
Preventive *(deductible waived)*	0%	20%
Basic Services	0%	20%
Major Services	20%	20%
Orthodontia Services	Not Covered	Not Covered
Adult	N/A	N/A
Child up to age 26	N/A	N/A
Lifetime Maximum	N/A	N/A

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations, and exclusions.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations, and exclusions.

TIP

Choose your Primary Care Dentist

When using a Dental PPO plan, you can receive services from dental providers both in and out of your insurance network. However, you'll receive better coverage when you use an in-network dentist. To determine whether your dentist is in or out of your insurance network, go to www.deltadentalaz.com/provider-search and search the provider network, or call Delta Dental at 800-352-6132 Option 1.

Dental Cost Breakdown

NOAH
Neighborhood Outreach Access to Health

The rates below are effective January 1, 2022 – December 31, 2022.

Coverage Level	Payroll Deductions 24 Pays	Payroll Deductions 24 Pays
Delta Dental - Base Plan	Full-Time Semi-monthly	Part-Time Semi-monthly
Employee Only	$8.18	$10.63
Employee and Spouse/Registered Domestic Partner	$17.25	$22.43
Employee and Child(ren)	$17.58	$22.85
Employee and Family	$29.23	$38.00
Delta Dental – Buy-up Plan		
Employee Only	$15.22	$17.67
Employee and Spouse/Registered Domestic Partner	$32.12	$40.85
Employee and Child(ren)	$32.74	$42.57
Employee and Family	$54.42	$75.96
Delta Dental – Enhanced Plan		
Employee Only	$17.68	$24.73
Employee and Spouse/Registered Domestic Partner	$41.64	$54.56
Employee and Child(ren)	$43.38	$55.61
Employee and Family	$77.43	$92.43

Vision Plan

Vision coverage is offered by VSP Vision as a Preferred Provider Organization (PPO) plan. As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. To locate an in-network vision provider, visit www.vsp.com .

Plan Highlights	VSP Vision PPO	
	In-Network	**Out-of-Network**
	VSP Network	
Exam – Every 12 months	$10	Reimbursed up to $45
Materials Copay	$30	N/A
Lenses – Every 12 months		
Single	Covered in full after $30 copay	Reimbursed up to $30
Lined Bifocal	Covered in full after $30 copay	Reimbursed up to $50
Lined Trifocal	Covered in full after $30 copay	Reimbursed up to $65
Frames – Every 12 months		
Frames	$150 Frame Allowance, 20% off any amount billed above frame allowance *Extra $20 allowance on Featured frame brands	Reimbursed up to $70
Additional Pairs of Glasses	20% off unlimited additional pairs of prescription glasses and/or nonprescription sunglasses	N/A
Contacts – Every 12 months, in lieu of lenses & frames		
Medically Necessary	Covered in full after copay	Reimbursed up to $105
Elective	Covered in full, up to Contact lens allowance	Reimbursed up to $210
VSP Laser VisionCare Program Discounted access for laser vision correction services	Average savings of 15-20% off retail price or 5% off promotional price	

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations, and exclusions.

TIPS

Five tips for having an excellent view

Don't underestimate your eyes! The following tips can help you keep your eyes healthy:

- **Eat lots of dark green leaves and blackberries.**
- **Get regular eye exams.**
- **Allow your eyes to rest from the computer screen.**
- **Wear sunglasses to protect your eyes from bright light.**
- **Wear safety goggles whenever necessary.**

Vision Cost Breakdown

The rates below are effective January 1, 2022 – December 31, 2022.

Coverage Level	Payroll Deduction 24 Pays	Payroll Deduction 24 Pays
VSP Vision	Full-Time Semi-monthly	Part-Time Semi-monthly
Employee Only	$3.93	$3.93
Employee and Spouse/Registered Domestic Partner	$6.29	$6.29
Employee and Child(ren)	$6.42	$6.42
Employee and Family	$10.35	$10.35

Life and Disability

Basic Life and AD&D

In the event of your passing, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Paid for in full by Neighborhood Outreach Access to Health, the benefits outlined below are provided by The Hartford:

All Full & Part time active employees working a minimum of 20 hours per week, excluding Directors, Managers, NP's, PA's, Residents, Foundation VP's and Associate VP's, Physicians, Dentists, and Advanced Practitioners.

- Basic Life & matching AD&D Insurance
  - 1x annual earnings up to a maximum benefit of $200,000

Please note: Benefits will reduce by 45% at age 70.

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the "economic value" of the coverage provided to you.

Voluntary Life and AD&D

Full time and Part time employees working over 20 hours are eligible to supplement your employer paid insurance, additional Life and AD&D coverage for you and/or your dependents is available for purchase on a payroll deduction basis through The Hartford.

- **For employees:** Increments of $10,000 not to exceed 5x annual earnings or $500,000, whichever is less, with a guarantee issue benefit of $150,000 if you enroll in the plan within 30 days of your initial eligibility.
- **For your spouse:** Increments of $5,000 up to $250,000 not to exceed 50% of the employee elected and approved Voluntary Life Amount with a guarantee issue benefit of $30,000 if you enroll in the plan within 30 days of your initial eligibility.
- **For your child (ren):** 15 days old up to 26 years of age, increments of $5,000 to a maximum of $10,000.
- **Voluntary AD&D:** Coverage is available for purchase in the same amounts as voluntary life insurance amounts above.
  - **Exception:** Spouse Accidental Death & dismemberment (AD&D) $10,000 increments to $50,000 not to exceed 100% of the employee elected and approved Supplemental Life Insurance.

*Modified Open enrollment for 01/01/2022: Both employee and spouse are eligible for the 2 increments (10k is an increment for employee, 5k is an increment for spouse) increase not to exceed Guaranteed Issue.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

If you do not enroll in the plan within the initial enrollment period, any amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 70. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

Cost of Employee Voluntary Coverage

Age of Insured	Monthly Rate per $1,000
Less than 25	$0.022
25–29	$0.021
30–34	$0.026
35–39	$0.04
40–44	$0.059
45–49	$0.106
50–54	$0.143
55–59	$0.197
60–64	$0.272
65–69	$0.346
70–74	$0.626
75+	$1.807
AD&D	**$0.012**

Cost of Spousal Voluntary Coverage

Age of Insured	Monthly Rate per $1,000
Less than 25	$0.035
25–29	$0.031
30–34	$0.048
35–39	$0.066
40–44	$0.102
45–49	$0.189
50–54	$0.29
55–59	$0.384
60–64	$0.461
65–69	$0.582
70–74	$1.052
75+	$3.043
AD&D	**$0.013**

Dependent Child Coverage

Benefit Amount	Monthly Premium
Composite	
Per $1,000	$0.025
AD&D	**$0.013**

TIP

Required! Are Your Beneficiaries Up to Date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- **You can change your beneficiary designation at any time.**
- **You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.**
- **To select or change your beneficiary, logon to Paycom and update your beneficiary or contact The Hartford.**

Short & Long Term Disability

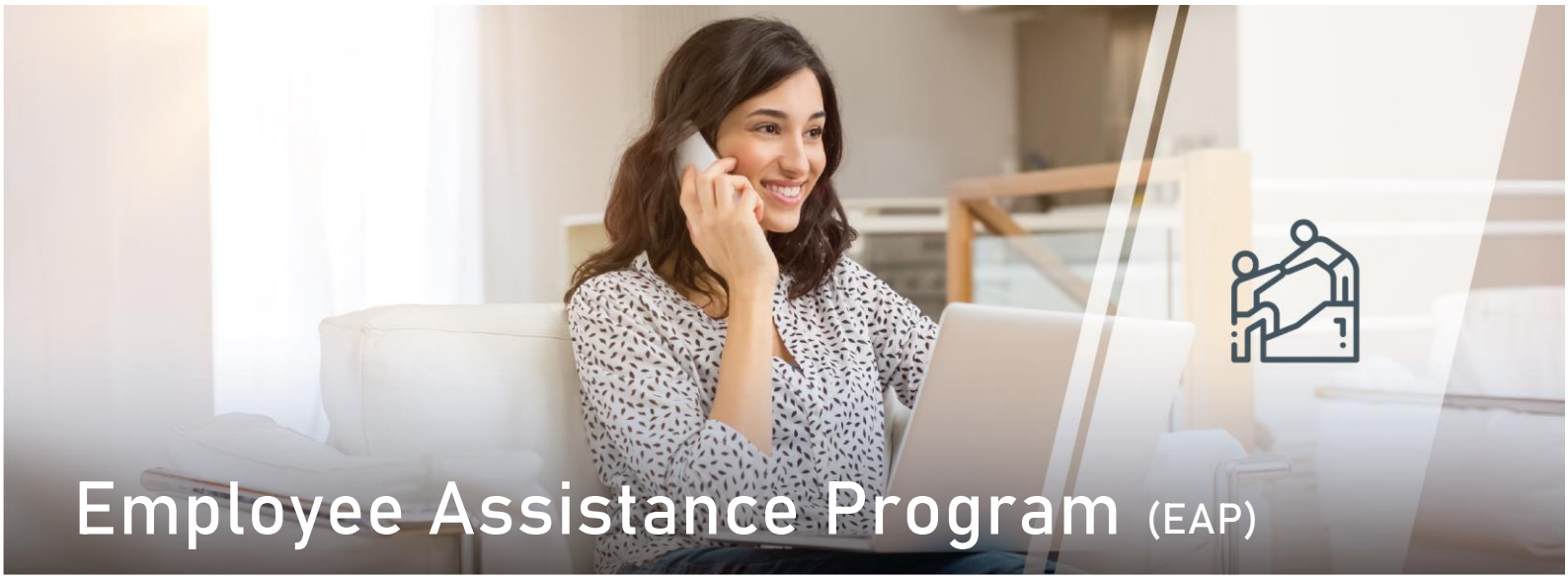
Added protection

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

Your Plans	Coverage Details
Employer Paid - Short Term Disability (STD)	• Administered by The Hartford, STD coverage provides a benefit equal to 60% of weekly earnings, up to $2,500 per week for a period up to 25 weeks. • The plan begins paying these benefits at the time of disability/after you have been absent from work for 7 consecutive days.
Employer Paid - Long Term Disability Coverage (LTD)	• If your disability extends beyond 180 days, the LTD coverage through The Hartford, can replace 60% of your monthly earnings, up to maximum of $15,000 per month. • Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability.

Tax considerations

Because disability coverage is an employer-paid benefit and is available for employees at no cost, any disability payments made to you will be taxable.



Employee Assistance Program (EAP)

Neighborhood Outreach Access to Health understands that you and your family members might experience a variety of personal or work-related challenges. Through Optum EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

Program Component	Coverage Details
Number of Sessions	6 face-to-face sessions per year per member per incident
How to Access	Phone or face-to-face sessions

Topics May Include	Mental Health Support:
	• Comprehensive telephonic assessments, solution focused consultations 24/7/365
	• Marital, relationship or family problems
	• Bereavement or grief counseling
	• Substance abuse and recovery
	
	Interactive Digital Resources:
	• Connection to 24/7 telephonic chat support, comprehensive self-help tools
	  ○ Sanvello
	  ○ Talkspace, text with a counselor M-F
	
	Financial and Legal Assistance
	• Legal counseling and referral services
	• Financial counseling and mediation
	
	Community WorkLife Services & Support:
	• Childcare resources/Parenting support
	• Adult/eldercare resources and support
	• Life learning educational support
	• Chronic condition support
	• Convenience services

Who Can Utilize	All employees, dependents of employees, and members of your household

TIP

Get in touch:

- **By Phone: 866.248.4096.**
- **Online: www.liveandworkwell.com**
- **Website password: NOAH**

Retirement Options

Your 403(b) Plan Option

Administered by Empower, the 403(b) plan allows you to plan for your future by investing a portion of each paycheck. Once you become eligible, you may elect to have a percentage of your paycheck withheld and invested in your 403(b) account, subject to federal law and plan guidelines. Eligibility requirements for the 403(b) are, Required Service, Age and Entry Dates.

Enrollment & Account Access

To enroll in the 403(b) plan, please visit https://participant.empower-retirement.com/participant/#/login to enroll online or contact Human Resources at NOAHHR@Honorhealth.com or 480-798-9739 to receive your enrollment forms.

Check your 403(b) account balance, view your contributions, change your investments and more by visiting https://participant.empower-retirement.com/participant/#/login. For login or password assistance please contact Empower at 855-756-4738.

Additional 403(b) Information

Contribution Limits: For 2021, the IRS annual contribution limits are $19,500 for everyone under age 50 or $26,000 for anyone that is age 50 or over prior to December 31, 2021. If you have multiple employers during the year, these limits are combined for all plans that you contribute to during the year. Restrictions may apply to these limits based on plan documents and annual testing requirements.

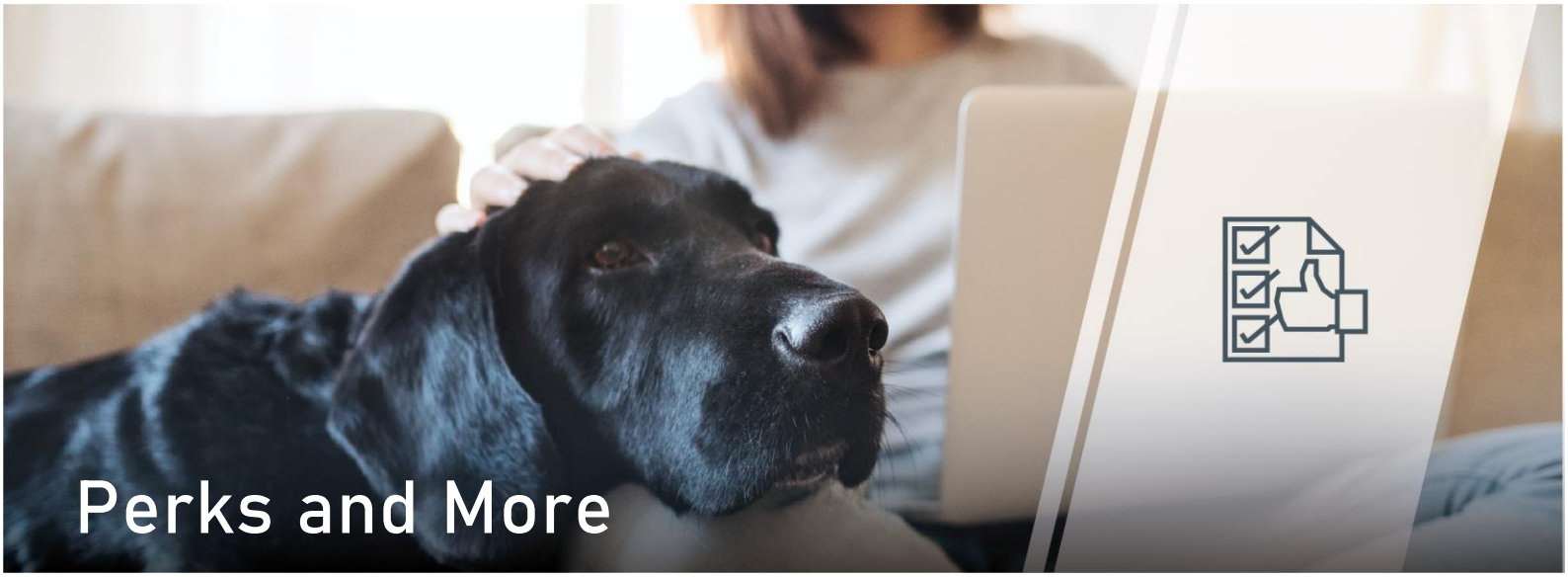
Contribution Changes: You may change the amount of your contribution each Pay Period, Monthly, Quarterly or other. You may also stop your contribution entirely at any time. Requests to change or stop your contributions must be made through the provider website or in writing to Human Resources.

Employer Contributions: A safe Harbor Match is offered to all eligible participants of 100% up to 4% of your eligible compensation. The match is contributed each pay period or annually after the end of each year, subject to company approval each year and may change in the future. Please check with Human Resources for the current match information.

Loans & Hardship Withdrawals: Our 403(b) plan allows for both loans and hardship withdrawals to be taken from your account while still employed with our company. Please see Human Resources for information and requirements for either option.

Rollover Contributions: If you have an outside qualified retirement plan or account such as a 401(k), 403(b), 457(b) or IRA, you may be able to transfer that account into your new plan. Please contact Empower or Human Resources for additional information.

Termination of Employment: Upon termination of employment from our organization, regardless of reason, you will be entitled to request a full distribution of your vested account balance. This may be done as a rollover to another qualified plan or IRA. You may also request a lump-sum cash payment to yourself. Please be aware of possible taxes and penalties which may apply to any payment other than a rollover.



Perks from Work

To round out your benefits package, we offer these additional perks to support both your personal and professional needs.

Holidays

The following paid holidays will be observed:

- New Year's Day.- Observed December 31, 2021
- Memorial Day - May 30th, 2022
- Independence Day - July 4th, 2022.
- Labor Day - September 5th, 2022
- Thanksgiving Day and the day after - November 24 & 25th, 2022
- Christmas – December 26, 2022

NOAH - Paid Time Off (PTO), Paid Sick Time (PST)

Non-Exempt/Exempt (PTO)	PTO Days/Year	Paid Holidays[2]	PST days/year[3]	Floating Holiday[4]
0-2	10	7	5	1
3-6 years	15	7	5	1
7-9 years	18	7	5	1
10-14 years	20	7	5	1
15+ years	22	7	5	1

[1] Paid Holidays dependent on approved clinic calendar
[2] Floating Holiday is frontloaded, not accrued
[3] PST accrual year Jan 1 - Dec 31

PST Accrual calculations

Length of Service	Earned PST	Max accrual per year
All	1 hour for every 30 hours worked (approx. 2.664 hours per pay period for full time employees)	40 hours

PTO Program Hour Accruals and Allotments

Length of Service	PTO Days Per Year**	PTO Hours Per Pay Period**	Accrual Per Hour	PTO Hours Per Year**	PTO Maximum Accrual***
0-2 yrs (0 to 24 months)	10	3.08	.038/hr	80	160
3-6 yrs (25 to 72 months)	15	4.62	.058/hr	120	240
7-9 yrs (73 to 108 months)	18	5.54	.069/hr	144	288
10-14 yrs (109 to 168 mos.)	22	6.77	.085/hr	176	300
15+ years (169+ months)	24	7.38	.092/hr	192	320

Bereavement Leave is provided in the following amounts:

NOAH offers Bereavement leave for all employees upon date of hire. Employees who lose an immediate family member are eligible for 3-5 days of paid bereavement leave.

Other Time off such as for family or medical reasons may be honored based on state and federal law.

Tuition Reimbursement

Neighborhood Outreach Access to Health supports your personal ambitions by offering you Tuition Reimbursement Benefits! Employees who have completed 6 months of employment may be eligible for tuition assistance for classes directly related to their position or another position at Neighborhood Outreach Access to Health. Classes must be approved in advance through HR process and guidelines. Please contact Human Resources for more information.

The Hartford – Value Added Services

- **Funeral Concierge Services** - Suite of online tools and live support, family advocacy and professional negotiations of funeral prices with local providers. To learn more information, call 866.854.5429 or visit www.everestfurneral.com/hartford. Use code:HFEVLC
- **Beneficiary Assist Services** – The Hartford offers you Beneficiary Assist counseling that can help you or your beneficiaries named in your policy code with emotional, financial and legal issues that arise after loss. Includes unlimited 24/7 phone access for legal and financial advice or emotional counseling with up to five face-to-face sessions, for up to a year from the date the claim is filed. For more information, call: 800.411.7239.
- **EstateGuidance & Will Services** - Through the Hartford you have access to EstateGuidance. It helps you protect your family's future by creating a will online – backed by online support from licensed attorneys. Just follow the instructions to create a will that's customized and legally binding. Visit: www.estateguidance.com Use code: WILLHLF
- **Travel Assistance & ID Theft Protection** - Travel Assistance with ID Theft Protection includes pre-trip information, to help you feel more secure while traveling. You can access professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less. ID Theft services are available to you and your family at home or when traveling. Call 800.243.6108, Collect from other locations: 202.828.5885, Travel Assistance Identification Number: GLD-09012
- **Ability Assist Counseling Services** - Offers 24/7 access to master's level clinicians, includes three face-to face visits per occurrence per year for emotional concerns and unlimited phone consultations for financial, legal, and work-life concerns.

  Call toll free: 800.964.3577 or Register visit, www.guidanceresource.com Use Company Code: HLF902 Use Company Name: ABILI Select "ability Assist Program" to create your own confidential user name and password.
- **HealthChampion SM2 Health Support Services** – HealthChampion offers Health Care Navigation support if you have become disabled or are diagnosed with a critical illness. You will receive guidance on care options, helpful resources and help with timely and fair resolution of issues Call toll free: 800-964-3577.

Supplemental Services

Pet Insurance

For many of us, our pets are just as special and loved as our family members. That is why it is important we protect their health too! Our Pet Insurance benefit, offered by United Pet Care, covers dogs, cats, birds and some other exotic animals. Some of the covered benefits for your pet may include allergies, diabetes, and cut or bite wounds, infections, heart failure, skin cancer, and more.

Check out the plans on United Pet Care's website by visiting www.unitedpetcare.com/NOAH or contact them to discuss the best coverage for your animal. For more information, please call 602-266-5303.

Veterinary Service	Choice Program $11.66 Monthly	Select Program $9.60 Monthly
Employees receive instant savings 20-50% off every veterinary visit! **United Pet Care features** • NO claim forms • NO deductibles • No waiting period • No age exclusions • No exclusion due to pre-existing or breed specific conditions		

Identity Theft

Neighborhood Outreach Access to Health offers protection for its employees from the hardships associated with identity theft. Through Allstate Identity Protection, employees can purchase industry-leading identity protection and fraud detection services on an individual basis, or for their families.

ProPlus Identity Theft Plan Rates

- Individual Rate: $9.95 per person per month
- Family Rate: $17.95 per family per month

Legal Services

Legal protection is just a tap away. MetLife Legal Plan is your provider for prepaid legal and financial services. MetLife Legal provides access to prepaid legal and financial services.

Legal representation includes such matters as:

- Real estate advice
- Family law
- Traffic offenses
- Estate planning and other financial issues
- Consumer protection
- Juvenile matters
- Legal document preparation and review

For additional information, contact MetLife Legal Plans Client Service Center at 1-800-821-6400 or visit **www.legalplans.com.** To learn more, or access plan information, please download the iNGAGED Benefit App with **Company Code: NOAH.** Your enrollment resources will be available by 10/12/2021.

Directory, and Required Notices

Directory & Resources

Below, please find important contact information and resources for Neighborhood Outreach Access to Health.

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
Human Resources: • Cassandra Marrujo / HR Director Online Enrollment Vendor: • Paycom	N/A	480-798-9739	cmarrujo@honorhealth.com NOAHHR@Honorhealth.com www.paycom.com
Medical Coverage			
AmeriBen • Coordinated Care Plan • Standard Plan • Health Savings Account Plan (HDHP) • AmeriBen – Pre-Certification	0122016	Customer Care: 855.961.5375 Pre-Certification: 855.961.5417	https://ameriben.com/MyAmeribenLogin.htm
Pharmacy Coverage			
• Navitus Health Solutions • Costco – Mail Order Pharmacy • Navitus SpecialtyRx – Lumicera Health Services	Carrier ID: NVNOA BIN/INN 610602 PCN: NVT RX Group: NOA	844.268.9789 - 855.847.3553	https://members.navitus.com https://pharmacy.costco.com
Dental Coverage			
Delta Dental • Dental Base	1003	800-352-6132 Opt 1	www.deltadentalaz.com or email customerservice@deltadentalaz.com
Vision Coverage			
Vision Service Plan (VSP) • Vision PPO		800.877.7195	www.vsp.com
Life, AD&D and Disability & Worksite			
The Hartford • Life & AD&D • Short Term Disability • Long Term Disability • Accident Insurance • Critical Illness Insurance • Hospital Indemnity	676659	Life & AD&D 888.563.1124 Disability 888.301.5615 Worksite 866.547.4205	https://www.abilityadvantage.thehartford.com https://www.TheHartford.com/benefits/myclaim
Flexible Spending Accounts			
WEX Health	42939	866.451.3399	https://benefitslogin.discoverybenefits.com/
Health Savings Account			
Health Equity		866.346.5800	www.healthequity.com
403(b) Retirement Plan Adviser			
Empower Retirement	NOAH	855.756.4738	https://participant.empower-retirement.com/participant/#/login
Employee Assistance Plan			
Optum EAP	Access Code: NOAH	866.248.4096	www.liveandworkwell.com

Information Regarding	Group / Policy #	Contact Information	
Pet Insurance			
United Pet Care	N/A	602.266.5303	www.unitedpetcare.com/NOAH
Identity Theft			
Allstate Identity Protection	6341	800.789.2720	https://portal.allstateidentityprotection.com/signin/
Legal Service			
MetLife Legal		800.821.6400	www.legalplans.com
Benefits Broker / Benefit Questions			
Lovitt & Touché, A Marsh & McLennan Insurance Agency LLC Claims Advocate- (Catherine Nault)	N/A	520.722.7155	cnault@lovitt-touche.com

Guidelines/Evidence of Coverage

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

Medicare Part D notice

Important Notice about Your Prescription Drug Coverage and Medicare

Model Individual CREDITABLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription 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 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.
2. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, 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 15 to December 7. 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 prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.

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 your employer and don't join a Medicare prescription 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 your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also 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 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 the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: **Keep this Creditable Coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

Legal Information Regarding Your Plans

REQUIRED NOTICES

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits 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; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

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, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 30 days after the marriage, birth, adoption, or placement for adoption.

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage [1]
- Acquisition of a new spouse or dependent through marriage [1], adoption [1], placement for adoption [1] or birth [1]
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) [1]
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

"Change in Status" Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved "change in status" as defined by the IRS.
- Examples of permitted "change in status" events include:
- Change in legal marital status (e.g., marriage [2], divorce or legal separation)
- Change in number of dependents (e.g., birth [2], adoption [2] or death)
- Change in eligibility of a child
- Change in your / your spouse's / your non registered domestic partner's employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse's / your non registered domestic partner's benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- A dependent's eligibility ceases resulting in a loss of coverage [3]
- Loss of other coverage [2]
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
- You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the following, which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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.

[1] Indicates that this event is also a qualified "Change in Status"
[2] Indicates this event is also a HIPAA Special Enrollment Right
[3] Indicates that this event is also a COBRA Qualifying Event

CONTINUATION COVERAGE RIGHTS UNDER COBRA (CONTINUED)

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 60 days after the qualifying event occurs. You must provide this notice to: AmeriBen.

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.

How is COBRA continuation coverage provided? (Continued)

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, Children's Health Insurance Program (CHIP), 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. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period [1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you

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

Neighborhood Outreach Access to Health
Attention: Cassandra Marrujo
Director of Human Resources
(7500 N. Dreamy Draw DR, Suite 145
Phoenix, AZ 85020
480-798-9739

For More Information

This notice doesn't fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact your Human Resources Representative.

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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.healthcare.gov.

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness [1]; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. [1]

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months [2], and if at least 50 employees are employed by the employer within 75 miles.

[1] The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition"

[2] Special hours of service eligibility requirements apply to airline flight crew employees

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627
www.wagehour.dol.gov

UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT NOTICE OF 1994, NOTICE OF RIGHT TO CONTINUED COVERAGE UNDER USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is EFFECTIVE: 1/1/2022

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

This notice is for participants in the Company Health & Welfare Plan (referred to as the "Plan"), including its component plans.

Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes; when for purposes of marketing; and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

Permitted Plan use of Your Health Information

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact the Plan Privacy Officer.

You have both the right and choice to tell us to: share information with your family, close friends, or others involved in payment for your care; share information in a disaster relief situation; and contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, the Plan may go ahead and share your information if it believes it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

Treatment: The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Payment for Health Services and Administration of the Plan: The Plan can use and disclose your health information when paying for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers' Compensation: We may release health information about you for workers' compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement and other Government Requests: We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety or for purposes of health research.

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Inspect and obtain a copy of your PHI contained in a "designated record set." A designated records set includes medical and billing records; enrollment, payment, billing, claims adjudication and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.
- Request an amendment/correction to your health information: you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- **Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.**
- **Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked "confidential" or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.**
- **Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.**
- **Receive notification within 60 days (5 day for California residents) for any breaches of your unsecured PHI.**
- **Assign someone as your medical power of attorney or your legal guardian, who can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.**

Plan Responsibilities

The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:

- **Maintain the privacy and security of your health information.**
- **Make reasonable efforts not to use, share, disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**
- **Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.**
- **Abide by the terms of this notice.**
- **Notify you if we are unable to agree to a requested restriction, amendment or other request.**
- **Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).**
- **Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.**

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Your Right to File a Complaint

If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer; or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Contact Person

If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

Neighborhood Outreach Access to Heath
Director of Human Resources
7500 N. Dreamy Draw DR, Suite 145
Phoenix, AZ 85020
480-798-9739

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 July 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ALASKA – Medicaid	**FLORIDA – 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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	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)	**MONTANA – 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: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – 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	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – 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)	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
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – 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: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	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
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	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 July 31, 2021, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Notice Regarding Availability of Health Insurance Exchange

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(Expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 2013 for coverage starting as early as January 1, 2014.

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 9.83% 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 Human Resources.

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.

[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 percent of such costs.

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.

3. Employer name Neighborhood Outreach Access to Health		4. Employer Identification Number (EIN) 27-3188239
5. Employer address 7500 N. Dreamy Draw., Suite 145		6. Employer phone number 480-798-9739
7. City Phoenix	8. State AZ	9. ZIP Code 85020
10. Who can we contact about employee health coverage at this job? Your employer's Human Resources Department, or for assistance with other types of available health insurance, contact MMA MarketLink: (844) 861-9458		
11. Phone number (if different from above) 480-798-9739	12. Email address cmarrujo@honorhealth.com	

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

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

  ☒ All employees. Eligible employees are:

  Full-time & Part-time active employees working 20 hours or more per week

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  Your legal Spouse or domestic partner (with affidavit), and dependent eligible children (up to age 26) or older who are or become disabled and dependent upon the employee.

  ☐ We do not offer coverage.

- ☒ If checked, this 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. Here's 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..

Notes

Prepared by: Marsh & McLennan Insurance Agency LLC
www.MarshMMA.com | CA Insurance Lic: 0H18131