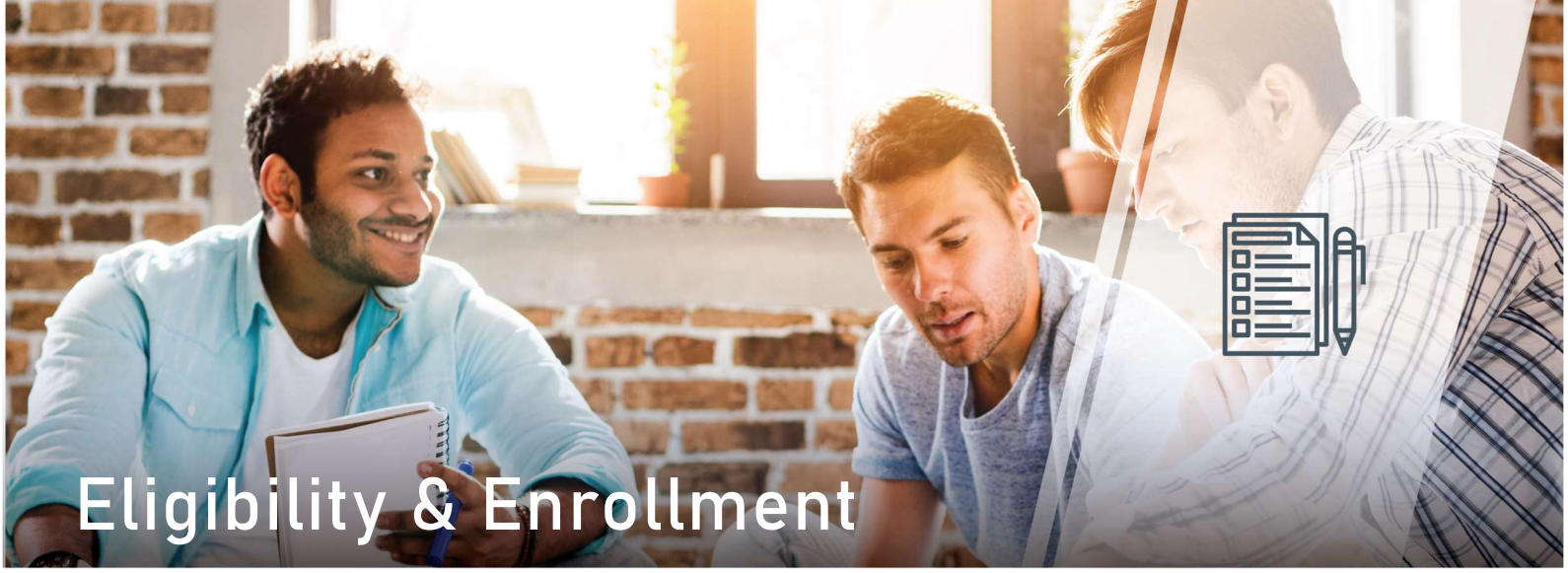

NOAH
Neighborhood Outreach Access to Health
2024
Benefits
Information Guide

Welcome to your 2024 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 36 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. You may choose to enroll your family members – including a legal spouse and any dependent child(ren) – and any other individual described in an eligible class for that benefit. You may be able to enroll a domestic partner and your domestic partner's child(ren) and may be required to enter into a registered domestic partnership or other official domestic partnership arrangement with a state in order to elect coverage for them.

You may be unable to pay for and/or receive employer contributions on a tax-free basis for the cost of coverage for your domestic partner and their child(ren) if any do not qualify as your tax dependent(s). It may be possible for a registered domestic partner and/or their child(ren) to qualify as your tax dependents for state tax purposes even when they do not qualify as your federal tax dependent(s).

When Does Coverage Begin?

Regular, full-time employees: Employees working 30 hours or more per week 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 per week are eligible to enroll on the first of the month following your date of hire for all benefits 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.

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 to the end of the benefits plan year, January 1, 2024 – December 31, 2024.

How Are Deductions Made?

NOAH has 26 pay dates within the year. However, benefit deductions are scheduled for only 24 pay dates within the calendar year.

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 get started with my enrollment?

paycom

Available as an app within the App Store or GooglePlay!

- Access the Paycom employee self-service website at www.paycom.com and select “Employee.”
- Enter your username, password, and the last four digits of your social security number. Then select “Log in.”
- After logging into Employee Self-Service, you will have an option under the “My Benefits” title in the center of the screen or on the left side of the page for “2024 Benefit Enrollment.” Click this button to be taken through the enrollment process.
- Once you complete the enrollment process, you can select “Complete Enrollment”. You will be brought to the “Sign and Submit” screen. A printable confirmation page is available to you. Once you are ready to submit your enrollment, click “Sign and Submit.”

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 is 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.

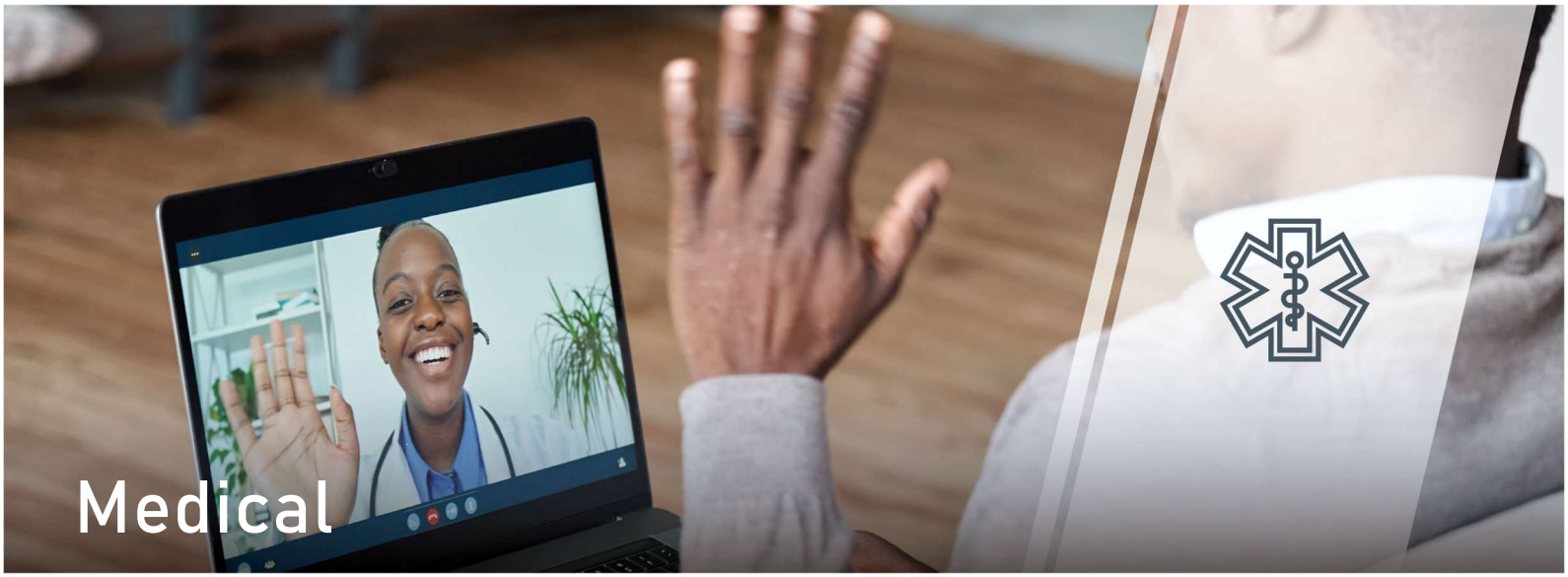
Do I Have to Enroll?

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, 2025 or if a qualifying status, change occurs.



Medical

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 an 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.

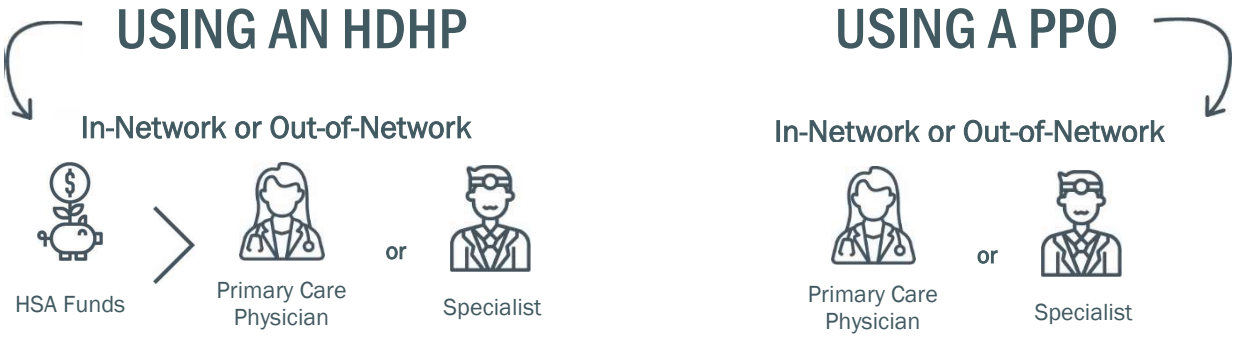
Please note the above examples are used for general illustrative purposes only. Please consult with your Human Resources department for more specific information as it relates to your specific plan. **To learn more** and view detailed plan information, download the "iNGAGED Benefits" app from the App Store or Google Play and use our Company Code **NOAH** to login to the app or login online at https://ingagedbenefits.com/login/

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.



Using an HDHP plan: an example

Taylor almost never goes to the doctor, but when she experienced a fever, chills, and chest congestion, she decided to visit urgent care. Taylor found a nearby in-network facility for treatment. Because Taylor hadn't yet met the plan's annual deductible, the health plan didn't cover the visit.
Taylor had savings set aside after choosing to pay less in monthly premiums, so this unusual visit wasn't a big deal. Taylor paid a $150 fee, which counts toward the plan's $3,500 annual deductible.

Using a PPO plan: an example

Syd was experiencing a lot of anxiety and wanted to see a psychiatrist. Syd went to the insurance company website and located an in-network provider. Syd paid a 10% coinsurance fee of $20 after visiting the psychiatrist. The psychiatrist prescribed a generic medication, which cost Syd a 20% coinsurance fee or $2.50. Both payments count toward Syd's $1,500 annual deductible.
The PPO plan was the best choice for Syd because planning for regular specialist visits was important. That can get expensive with a high-deductible plan. By choosing the PPO, Syd saved money and got great care.

Please note the examples above do not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

Plan Highlights	Base PPO Plan		Buy-Up PPO Plan	
	NOAH Provider	**In-Network Provider**	**NOAH Provider**	**In-Network Provider**
Annual Calendar Year Deductible				
Individual	$6,000		$750	
Family	$12,000		$1,500	
Maximum Out-of-pocket				
Individual	$6,450		$5,000	
Family	$12,900		$10,000	
Professional Services				
Primary Care Physician (PCP)	$5 copay	$35 copay	$5 copay	$35 copay
Specialist	$10 copay	$70 copay	$10 copay	$70 copay
Telehealth Visit	N/A	$20 copay	N/A	$20 copay
Preventive Care Exam	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Diagnostic Laboratory Service X-ray,	$5 copay	$35 copay	$5 copay	$35 copay
Complex Diagnostics (MRI/CT Scan)	N/A	$150 copay	N/A	$150 copay
Hospital Services				
Inpatient	N/A	20% after ded	N/A	20% after ded
Outpatient Surgery	N/A	20% after ded	N/A	20% after ded
Urgent Care	N/A	$70 copay	N/A	$70 copay
Emergency Room	$250 copay		$250 copay	
Mental Health & Substance Abuse				
Inpatient	N/A	20% after ded	N/A	20% after ded
Outpatient Office visit Other Outpatient Services	$5 copay 10% after ded	$35 copay 20% after ded	$5 copay 10% after ded	$35 copay 20% after ded
Retail 30-Day Prescription Drugs				
ACA Preventative Maintenance Medications	No charge, deductible waived		No charge, deductible waived	
Tier 1 – Retail Generic	$10 copay		$10 copay	
Tier 2 – Retail Preferred	$20 copay		$20 copay	
Tier 3 – Retail Non-Preferred	$50 copay		$50 copay	
Retail 90-Day Prescription Drugs				
ACA Preventative Maintenance Medications	No charge, deductible waived		No charge, deductible waived	
Tier 1 – Retail Generic	$25 copay		$25 copay	
Tier 2 – Retail Preferred	$50 copay		$50 copay	
Tier 3 – Retail Non-Preferred	$125 copay		$125 copay	
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		$25 copay	
Tier 2 – Mail Order Preferred	$50 copay		$50 copay	
Tier 3 – Mail Order Non-Preferred	$125 copay		$125 copay	
Specialty Drugs – Lumicera	$250 copay		$250 copay	

Plan Highlights

Health Savings Account Plan (HDHP)

	NOAH Provider	In-Network Provider
Annual Calendar Year Deductible		
Individual	$3,200	
Family	$6,400	
Maximum Out-of-pocket		
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	N/A	20% after deductible
Preventive Care Exam	Plan Pays 100%	Plan Pays 100%
Diagnostic X-ray and Lab	10% after deductible	20% after deductible
Complex Diagnostics (MRI/CT Scan)	10% after deductible	20% after deductible
Hospital Services		
Inpatient	N/A	20% after deductible
Outpatient Surgery	N/A	20% after deductible
Urgent Care	20% after deductible	
Emergency Room	20% after deductible	
Mental Health & Substance Abuse		
Inpatient	N/A	20% after deductible
Outpatient	10% after deductible	20% after deductible
Retail 30-Day Prescription Drugs		
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Tier 2 – Mail Order Preferred	$50 copay after deductible	
Tier 3 – Mail Order Non-Preferred	$125 copay after deductible	
Specialty Drugs – Lumicera	$250 copay after deductible	

Medical Cost Breakdown

The rates below are effective January 1, 2024 – December 31, 2024.

Coverage Level	Semi-Monthly (24 Pay Period Deductions)	Semi-Monthly (24 Pay Period Deductions)
	Full-Time Employee	**Part-Time Employee**
AmeriBen - Base PPO Plan		
Employee Only	$25.00	$62.50
Employee and Spouse/Registered Domestic Partner	$82.50	$206.25
Employee and Child(ren)	$75.00	$187.50
Employee and Family	$130.00	$325.00
AmeriBen - Buy-Up PPO Plan		
Employee Only	$82.50	$206.25
Employee and Spouse/Registered Domestic Partner	$240.00	$600.00
Employee and Child(ren)	$185.00	$462.50
Employee and Family	$385.00	$962.50
AmeriBen – High Deductible Health Plan		
Employee Only	$40.00	$100.00
Employee and Spouse/Registered Domestic Partner	$120.00	$300.00
Employee and Child(ren)	$86.40	$216.00
Employee and Family	$200.00	$500.00

To learn more and view detailed plan information, 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 https://ingagedbenefits.com/login/

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 but are less expensive.
- 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. This is because there is an alternative proven to be just as effective and safe, but less costly. Ask your doctor or pharmacist for additional information regarding generic options.

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 of Retail or Mail Order; the choice is yours!

Copay Max Plus – **PPO Plans Only**

Under the Copay Max Plus Program, if your prescription has copay assistance that you qualify for, the amount you pay for select medications may be reduced to $0!

If your medication is eligible for this program Navitus may put a hold on your first fill (or first fill after 1/1/2024) and ask you to call in to speak with Member Services to prescreen you for eligibility.

If you are not eligible, they will release your medication to be filled normally.

If you do qualify, Navitus will ensure you can pick up a limited supply of medication to get you through until the discounted pricing can be applied.

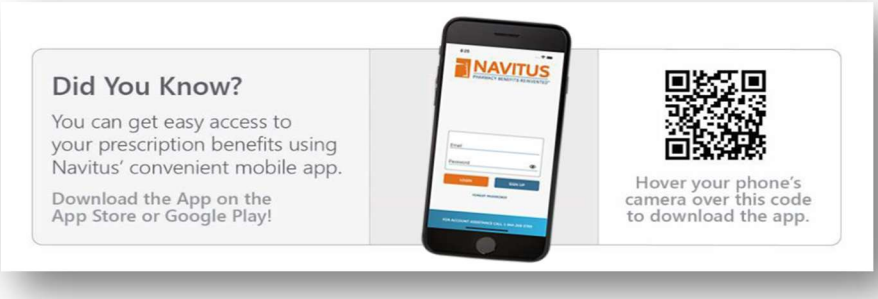
Specialty Medications Pharmacy - Lumicera Health Services

Specialty medications 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 making a trip to a walk-in pharmacy. It is easy to begin using Costco Pharmacy, register online at www.costco.com/home-delivery

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 1.844.268.9789. 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 for prescriptions?

Use Mail Order

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 making a trip to a walk-in pharmacy.

Shop Around

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

Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive alternative 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 https://ingagedbenefits.com/login/, **Company Code: NOAH**

How to Find a Provider

Neighborhood Outreach Access to Health

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

BlueCross Blue Shield of Arizona Network

1. Go to www.azblue.com and click "Find Care"
2. Choose "Find a Doctor, Provider, or Facility"
3. Choose "Browse the network as a guest"
4. From the dropdowns select "2024" for the coverage year, "Employer Provided" for type of coverage, and "Statewide or National PPO" for network
5. You are now ready to search for a provider.
6. Call 1.855.961.5370

- **The Innovative Partners Network is no longer available.**

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

Prescriptions

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: $55
    - Dermatology: $85 consultation fee
    - Behavioral Health e-visits are based on providers specialty and type of e-visit
        - Psychiatry: $220 Initial visit/$100 ongoing
        - Psychology/Therapy: $90

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 contribute up to the following amounts:
  - $960 to your HSA for employee-only or employee and spouse/domestic partner coverage
  - $1,920 to your HSA for employee and child(ren) or employee and family coverage
  - **Note**: employees must enroll/open an HSA account to receive employer contributions

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.[2]
- You are not claimed as a dependent on someone else's tax return (excluding a spouse).
- you have not received any hospital care or medical services from the Veterans Administration, in the last three months (unless these services were related to a service-connected disability)[3]
- You are not enrolled in a general Health Care Flexible Spending Account (Health FSA) or general Health Reimbursement Arrangement (HRA).

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

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

(3) 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 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.

A few rules you need to know:

- For 2024, the maximum contribution limit for employee and employer contributions in an employee's HSA account is $4,150 if you are enrolled in the HDHP for employee-only coverage, and $8,300 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, you may also be covered by a Limited Purpose Health Care FSA, 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 the 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 they were eligible to contribute to an HSA in the first year, if they are 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**

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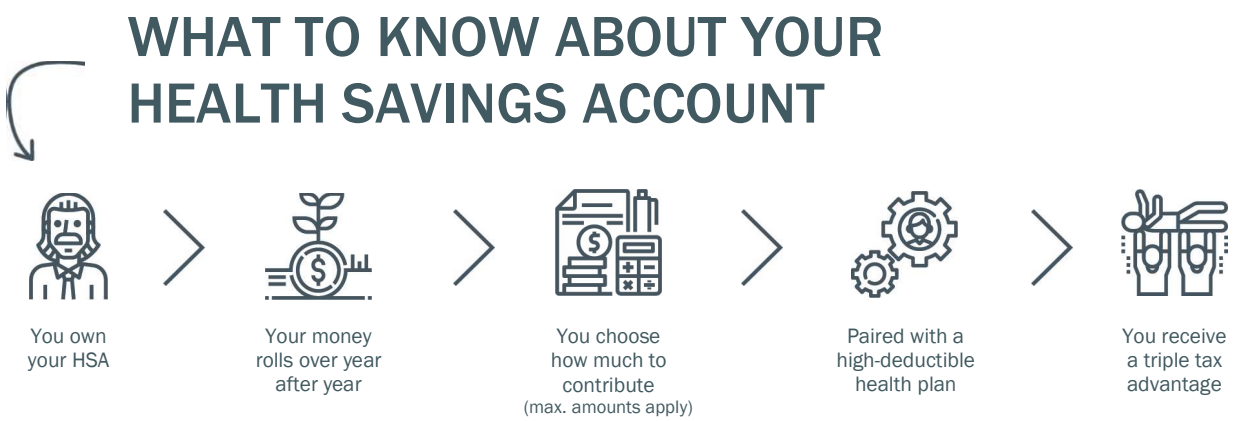


Flexible Spending Accounts (FSA)

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 2024 is $3,200.
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 2024 is $3,200.
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 2024 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.

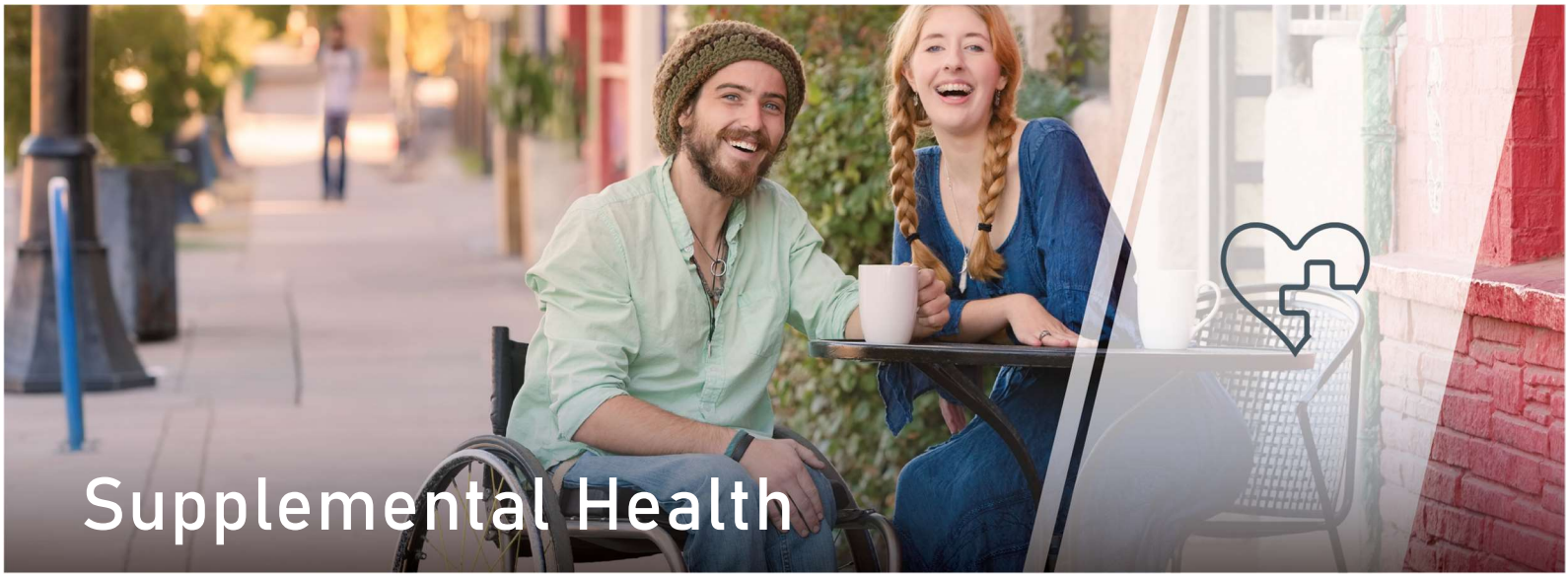
How do I use it?

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 reimbursement status, and more. Visit https://benefitslogin.wexhealth.com/Login.aspx?ReturnUrl=%2f to access WEX Health's online portal.

A few rules you need to know:

- You may carryover up to $610 from your 2023 Health FSA to the 2024 plan year
- For more details about using an FSA, contact WEX Health at 1.866.451.3399 or visit: https://benefitslogin.wexhealth.com/Login.aspx?ReturnUrl=%2f

To learn more and view detailed plan information, 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 https://ingagedbenefits.com/login/



Critical Illness Coverage

Critical Illness coverage offered on a voluntary basis through Unum 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 example above does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

Benefit options

Election	Benefit Amounts & Guaranteed Issue
Employee	$10,000, $20,000, or $30,000 (All Guaranteed Issue)
Spouse	Up to 100% of Employee benefit election (All Guaranteed Issue)
Child(ren)	From live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 100% of Employee benefit election.

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** and view detailed plan information, 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 https://ingagedbenefits.com/login/.

100% Employee-paid:

If you elect the voluntary Critical Illness plan, 100% of the cost is deducted through payroll deductions.

Critical Illness Semi-Monthly Cost of Employee & Family Voluntary Coverage						
Age	Employee (includes Children) – $10K Benefit	Spouse / Domestic Partner – $10K Benefit	Employee (includes Children) - $20K Benefit	Spouse / Domestic Partner – $20K Benefit	Employee (includes Children) - $30K Benefit	Spouse / Domestic Partner - $30K Benefit
<25	$1.83	$1.83	$2.73	$2.73	$3.63	$3.63
25-29	$2.23	$2.23	$3.53	$3.53	$4.83	$4.83
30-34	$2.73	$2.73	$4.53	$4.53	$6.33	$6.33
35-39	$3.53	$3.53	$6.13	$6.13	$8.73	$8.73
40-44	$4.53	$4.53	$8.13	$8.13	$11.73	$11.73
45-49	$5.78	$5.78	$10.63	$10.63	$15.48	$15.48
50-54	$7.23	$7.23	$13.53	$13.53	$19.83	$19.83
55-59	$9.68	$9.68	$18.43	$18.43	$27.18	$27.18
60-64	$13.23	$13.23	$25.53	$25.53	$37.83	$37.83
65-69	$18.98	$18.98	$37.03	$37.03	$55.08	$55.08
70-74	$29.38	$29.38	$57.83	$57.83	$86.28	$86.28
75-79	$43.08	$43.08	$85.23	$85.23	$127.38	$127.38
80-85	$62.58	$62.58	$124.23	$124.23	$185.88	$185.88
85+	$100.53	$100.53	$200.13	$200.13	$299.73	$299.73

Rates are based on the attained age of the employee and increase as new age categories are entered.

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 and view detailed plan information, 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 https://ingagedbenefits.com/login/ Company Code: **NOAH**

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 Unum 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 example above 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. Semi-Monthly post-tax rates are outlined below:

Election	Semi-Monthly (24 Pay Period Deductions)
Employee Only	$7.94
Employee + Spouse	$13.25
Employee + Child(ren)	$11.34
Family	$16.65

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** and view detailed plan information, 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 https://ingagedbenefits.com/login/

Accident Insurance Plan

Accident Insurance offered on a voluntary basis through Unum 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 $1,300 to help pay for Molly's expenses associated with her accident.

Please note the example above 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.
Semi-Monthly post-tax rates are outlined below:

Election	Semi-Monthly (24 Pay Period Deductions)
Employee Only	$4.72
Employee + Spouse	$8.32
Employee + Child(ren)	$9.74
Family	$13.34

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** and view detailed plan information, 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 https://ingagedbenefits.com/login/

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.

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. 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.

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.

To learn more and view detailed plan information, 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 https://ingagedbenefits.com/login/

Dental Cost Breakdown

The rates below are effective January 1, 2024 – December 31, 2024.

Coverage Level	Semi-Monthly (24 Pay Period Deductions)	Semi-Monthly (24 Pay Period Deductions)
Delta Dental – Base Plan	Full-Time	Part-Time
Employee Only	$8.32	$9.15
Employee and Spouse/Registered Domestic Partner	$15.46	$17.01
Employee and Child(ren)	$18.52	$20.38
Employee and Family	$25.88	$28.47
Delta Dental – Buy-up Plan		
Employee Only	$17.28	$19.28
Employee and Spouse/Registered Domestic Partner	$25.50	$29.50
Employee and Child(ren)	$38.03	$42.03
Employee and Family	$40.63	$44.63
Delta Dental – Enhanced Plan		
Employee Only	$21.60	$23.76
Employee and Spouse/Registered Domestic Partner	$43.65	$48.02
Employee and Child(ren)	$53.10	$58.41
Employee and Family	$65.15	$71.66

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. If frames exceed $150, an additional 20% of the excess amount will be covered. Extra $20 frame allowance on featured 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**

To learn more and view detailed plan information, 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 https://ingagedbenefits.com/login/

Vision Cost Breakdown

The rates below are effective January 1, 2024 – December 31, 2024.

Coverage Level	Semi-Monthly (24 Pay Period Deductions)	Semi-Monthly (24 Pay Period Deductions)
VSP Vision	Full-Time	Part-Time
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 Unum:

All Full & Part-Time Active Employees who are Physicians, Directors, Managers, NPs, PAs, Residents, Foundation VPs, and Associate VPs.

- Basic Life and matching AD&D Insurance
    - 2x annual earnings up to a maximum of $400,000

All Full & Part-Time active employees working a minimum of 20 hours per week who are not covered in another group.

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

Please note: Benefits will reduce to 65% of the original amount when you reach age 70 and 50% at age 75.

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

All Full & 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 Unum.

- **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 100% 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):** live birth to 6 months flat $1,000. 6 months up to 26 years of age, increments of $2,000 to a maximum of $10,000. One policy covers all of your children.
- **Voluntary AD&D:** Coverage is available for purchase in the same amounts as voluntary life insurance amounts above.

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 to 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
15–24	$0.020
25–29	$0.020
30–34	$0.030
35–39	$0.050
40–44	$0.070
45–49	$0.110
50–54	$0.170
55–59	$0.240
60–64	$0.290
65–69	$0.390
70–74	$0.710
75+	$2.390
AD&D	$0.025

Cost of Spousal Voluntary Coverage

Age of Insured	Monthly Rate per $1,000
15–24	$0.020
25–29	$0.020
30–34	$0.030
35–39	$0.050
40–44	$0.070
45–49	$0.110
50–54	$0.170
55–59	$0.240
60–64	$0.290
65–69	$0.390
70–74	$0.710
75+	$2.390
AD&D	$0.025

Dependent Child Coverage

Benefit Amount	Monthly Premium
Composite	
Per $1,000	$0.428
AD&D	$0.100

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, login to Paycom and update your beneficiary or contact Unum.**

To learn more and view detailed plan information, 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 https://ingagedbenefits.com/login/

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 Coverage (STD)	• Administered by Unum, STD coverage provides a benefit equal to 60% of weekly earnings, up to $2,500 per week • Maximum Benefit Period up to 24 weeks. • The plan begins paying these benefits at the time of disability/after you have been absent from work for 14 consecutive days.
Employer-Paid Long Term Disability Coverage (LTD)	• If your disability extends beyond 180 days, the LTD coverage through Unum, 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.

To learn more and view detailed plan information, 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 https://ingagedbenefits.com/login/

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 and Unum 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 (Optum) 3 face-to-face sessions per member per incident (Unum)
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 (available through Optum services):
	• 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

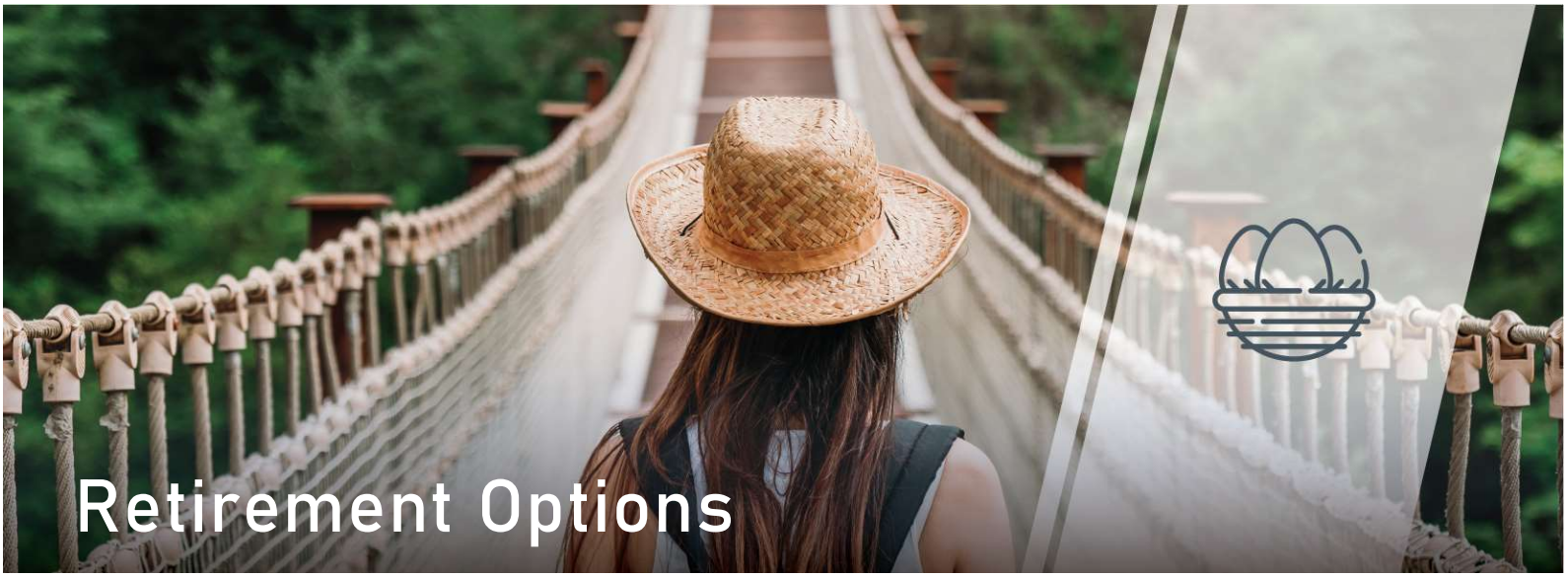
Get in touch (Optum):

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

TIP

Get in touch (Unum):

- **By Phone: 800.854.1446**
- **Online: www.unum.com/lifebalance**



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 benefits@noahhelps.org or 602.601.2451 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 2023, the IRS annual contribution limits are $22,500* for everyone under age 50 or $30,000* for anyone that is age 50 or over prior to December 31, 2023. 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.

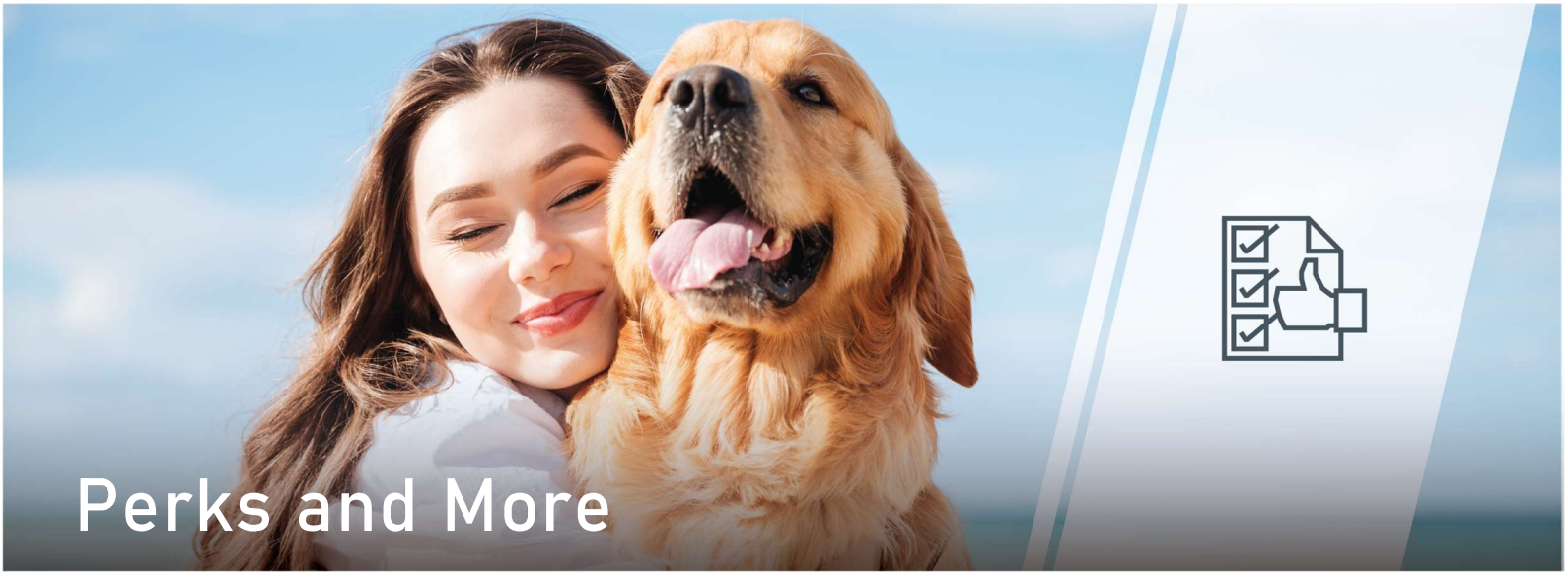
Employer Contributions: A discretionary match is offered to all eligible participants of 100% up to 4% of your eligible compensation. The match is contributed each pay period or annually after the end of each year, subject to company approval each year and may change in the future. Please check with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

***Note**: 2023 limits provided. 2024 limits were not available as of the date of publication. You may contribute up to the 2024 limit, which will be published on www.irs.gov



Employee Perks

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 - January 1, 2024
- Cesar Chavez Day - April 1, 2024
- Memorial Day - May 27, 2024
- Juneteenth - June 19, 2024
- Independence Day - July 4, 2024
- Labor Day - September 2, 2024
- Thanksgiving Day and the day after - November 28 & 29, 2024
- Christmas – December 25, 2024
- 1 Floating Holiday

Tuition Reimbursement

Neighborhood Outreach Access to Health supports your personal ambitions by offering you tuition reimbursement benefits! Employees who have completed six 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.

Unum – Value Added Services

Travel Assistance – whenever you travel 100 miles or more from home be sure to pack your travel assistance phone number. Here are some of the benefits of emergency travel assistance:

- Help replacing lost prescriptions and passports
- Referrals to western-trained, English-speaking medical providers and hospital admission assistance
- Emergency medical evacuation
- Transportation for a friend or family member to join a hospitalized patient
- Care and transport of unattended minor children
- Legal and interpreter referrals

if you need travel assistance anywhere in the world contact Assist America, day or night:

- **Within the US:** 1.800.872.1414 **Outside the US:** +1.609.986.1234
- **Email:** medservices@assistamerica.com **Mobile App:** download the Assist America app

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/enroll or contact them to discuss the best coverage for your animal. For more information, please call 877.872.8800.

Program Pricing per semi-monthly pay period deduction (24):	1 Pet $9.75	2 Pets $19.00	3 Pets $28.25	Each Additional $9.25

Employees receive instant savings 20-50% off every veterinary visit!

United Pet Care features:

- Access to 24/7 Pet Healthline
- No claim forms
- No deductibles
- No waiting periods No age exclusions
- No exclusions due to pre-existing or breed specific conditions
- No age exclusions

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: $4.98 per person, per semi-monthly 24 pay period deduction
- Family Rate: $8.98 per family, per semi-monthly 24 pay period deduction

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.

MetLife Legal Plan Rate:

- $9.75 per semi-monthly 24 pay period deduction

Legal representation examples include:

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

For additional information, contact MetLife Legal Plans Client Service Center at 1-800-821-6400 or visit **www.legalplans.com. To learn more** and view detailed plan information, 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 https://ingagedbenefits.com/login/, Company Code**: NOAH**

Directory and Required Notices

Directory and Resources

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
Human Resources: • Kat Bergman / HR Benefits Manager Online Enrollment Vendor: • Paycom	N/A	602.601.2451	kabergman@noahhelps.org www.paycom.com
Medical Coverage			
AmeriBen • Base • Buy-up • Health Savings Account Plan (HDHP) • AmeriBen – Pre-Certification	NAH001	Customer Care: 855.961.5370 Pre-Certification: 855.961.5417	www.myameriben.com
Telemedicine			
TelaDoc	TELG454828	800.835.2362	www.teladoc.com
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 PPO	1003	800.352.6132 Opt 1	www.deltadentalaz.com or email customerservice@deltadentalaz.com
Vision Coverage			
Vision Service Plan (VSP) • Vision PPO	30107133	800.877.7195	www.vsp.com
Life, AD&D and Disability & Worksite			
Unum • Basic Life & AD&D • Voluntary Life & AD&D • Short Term Disability • Long Term Disability • Accident Insurance • Critical Illness Insurance • Hospital Indemnity	 946399 946400 946399 946399 946402 946401 946403	866.679.3054	www.unum.com
Flexible Spending Accounts			
WEX Health	42939	866.451.3399	https://benefitslogin.wexhealth.com/Login.aspx?ReturnUrl=%2f
Health Savings Account			
HealthEquity	4176554	866.346.5800	www.healthequity.com
403(b) Retirement Plan Adviser			
Empower Retirement	NOAH	855.756.4738	https://participant.empower-retirement.com/participant/#/login

Information Regarding	Group / Policy #	Contact Information	
Employee Assistance Plan			
Optum EAP	Access Code: NOAH	866.248.4096	www.liveandworkwell.com
Pet Insurance			
United Pet Care	N/A	877.872.8800	www.unitedpetcare.com/enroll
Identity Theft			
Allstate Identity Protection	6341	800.789.2720	https://portal.allstateidentityprotection.com/signin/
Legal Service			
MetLife Legal	5392558	800.821.6400	www.legalplans.com
Benefits Broker / Benefit Questions			
Lovitt & Touché, A Marsh & McLennan Insurance Agency LLC Claims Advocate- Shan O'Connor	N/A	520.722.7155	soconnor@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
Creditable Coverage Notice

Important Notice from Neighborhood Outreach Access to Heath
About Your Prescription Drug Coverage and Medicare

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

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

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. Neighborhood Outreach Access to Heath has determined that the prescription drug coverage offered by the Neighborhood Outreach Access to Heath Medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan while enrolled in Neighborhood Outreach Access to Heath coverage as an active employee, please note that your Neighborhood Outreach Access to Heath coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually

pay primary for your prescription drug benefits if you participate in Neighborhood Outreach Access to Heath coverage as a former employee.

You may also choose to drop your Neighborhood Outreach Access to Heath coverage. If you do decide to join a Medicare drug plan and drop your current Neighborhood Outreach Access to Heath coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Neighborhood Outreach Access to Heath and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Neighborhood Outreach Access to Heath 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 Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare 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).

Date: 01/01/2024
Name of Entity/Sender: Neighborhood Outreach Access to Heath
Contact Position/Office: Kat Bergman / Human Resources Benefit Manager
Address: 7500 N. Dreamy Draw Dr, Suite 145, Phoenix, AZ 85020
Phone Number: 602.601.2451

Summary Material Modification

Changes effective 01/01/2024:

AmeriBen Medical Plan Changes:

2023 Benefits	2024 Benefits Changes
High Deductible Health Plan (HDHP) In-network Deductible $3,000 / $6,000	**High Deductible Health Plan (HDHP)** In-network Deductible $3,200 / $6,400

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Neighborhood Outreach Access to Heath group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days 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.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact Kat Bergman at 602.601.2451.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Neighborhood Outreach Access to Heath ("NOAH") sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of NOAH, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by NOAH, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the NOAH HIPAA Privacy Officer:

Neighborhood Outreach Access to Heath
Attention: HIPAA Privacy Officer
7500 N. Dreamy Draw Dr, Suite 145,
Phoenix, AZ 85020
602.601.2451

Effective Date

This Notice as revised is effective January 1, 2024.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA.

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

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

To see if any other states have added a premium assistance program since January 31, 2023, 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

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a 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. If you would like more information on WHCRA benefits, contact your plan administrator at 602.601.2451.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

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

Model General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

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

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed

later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- 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 Kat Bergman.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect

COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, 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

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

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/agencies/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: Kat Bergman / Human Resources Benefit Manager
7500 N. Dreamy Draw Dr, Suite 145
Phoenix, AZ 85020
602.601.2451

HIPAA Notice of Availability of Notice of Privacy Practices

The Neighborhood Outreach Access to Health Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Kat Bergman at 602.601.2451.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:

    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills and for contact information for the state department of insurance or other similar agency/resource in your state to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.

Notice Regarding Availability of Health Insurance Exchange

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210–0149

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 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[2]

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.

[2] 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 Dr, Suite 145		6. Employer phone number 602.601.2451
7. City Phoenix	8. State AZ	9. ZIP Code 85020
10. Who can we contact about employee health coverage at this job? Human Resources Benefit Manager		
11. Phone number (if different from above)		12. Email address kabergman@noahhelps.org

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.

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