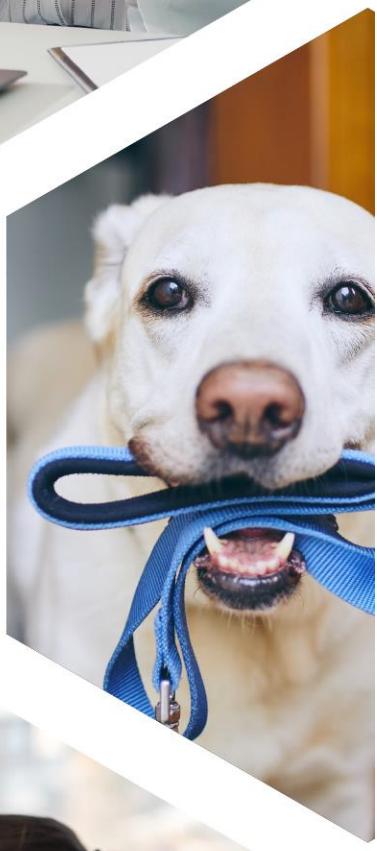
NOAH
Neighborhood Outreach Access to Health



Benefits Information Guide

2025

Welcome

Your time with your team is important, but there's more to life than work. The benefits you'll find here are carefully chosen to support your life outside of work, whatever it looks like for you. Whether you're checking it out for the first time or stopping by for a visit, this guide is crafted to help you choose the right benefits. We'll talk about medical, dental, spending accounts, retirement, and more.

We'll also help you put those benefits to use whenever you need them throughout the plan year. You'll find answers to important questions like "How do I add my new kid to my insurance?" or "How much vacation time do I get, again?"

Grab a cup of coffee, tea, or plant milk, and let's get started.

Plan summary

Does this guide contain everything I need to know about my health plan?

While there are many brief benefit summaries listed throughout this guide, they're just that: summaries. When you're trying to figure out whether a medical service or a medical supply will be paid for by your health plan, it's best to take a look at the Evidence of Coverage or Summary Plan Description as well.

One important thing to note is that in order for a service or supply to be paid for by your health plan, it must be overseen by a doctor. Some of the guidelines for coverage also come down to the type of plan you choose which you'll learn more about in this guide.

There's more important information in your health plan documents called Evidence of Coverage and Summary Plan Description. These documents have more details about your coverage. You can find them in your benefit administration portal, or by contacting HR. They're the final place you'll need to look if you have questions about your coverage because they're the binding agreement between you and the plan.

If you notice differences between benefits in this guide and the Evidence of Coverage or Summary Plan Description, you should go by what's written in those documents, not this guide.

When you ask your health plan to cover a supply or service, it's called a "claim." These documents have the information you need to get your claim reviewed or to dispute it if you think there's been an error.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see page 45 for more details.

Check out your benefits

Dig into options, programs, and resources.

Get benefits info on your phone!

iNGAGED

Have you ever arrived at the doctor's office only to realize you left your new insurance card at home? With the iNGAGED app, this familiar scenario is a thing of the past. The app stores all your benefits information so it's always there when you need it. You can see our benefits offerings and resources, quickly contact our insurance carriers, store images of your insurance ID card, and view your group numbers.

Find it under "iNGAGED Benefits" on the App Store or Google Play, or go to http://www.portal.ingaged.me/login and use company code **NOAH** to log in.

Keep an eye out for benefit examples

Quick note: these examples are meant to help you understand the different health plans we offer. If you have specific questions, it's a good idea to reach out to Human Resources. You can also read the details and fine print of your plan summaries at https://www.portal.ingaged.me/login.

Fixed Indemnity Policy Notice

UNUM – Hospital Insurance

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Eligibility & Enrollment

Eligibility & Enrollment

Quick answers to your questions

Who can sign up?

All employees who regularly work at least 16 hours per week are eligible to participate in the benefits program. More good news: you can also cover your spouse, eligible child(ren), and any other individual described in an eligible class for that benefit. Just keep in mind, you 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 a domestic partner or your domestic partner's child(ren). Coverage for your domestic partner and children will not be tax-free if they 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 my coverage start?

Regular, full-time employees: Employees working 30 hours or more per week are eligible to enroll on the first of the month following 30-days from 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 working 16 hours or more per week are eligible to enroll on the first of the month following 30-days from 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.

Variable-hour employees: You are eligible to enroll at the end of your Measurement Period (initial or standard) if you successfully average 16 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.

Once you enroll in a benefits plan, you can't make any changes until the end of the plan year, which is from January 1, 2025, to December 31, 2025.

If you miss the deadline to sign up, you can't enroll later unless you experience what's called a Qualifying Life Event Change. It's always a good idea to check with your plan administrator and your section 125 plan document to see if you're allowed to make a mid-year change based on your situation.

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.

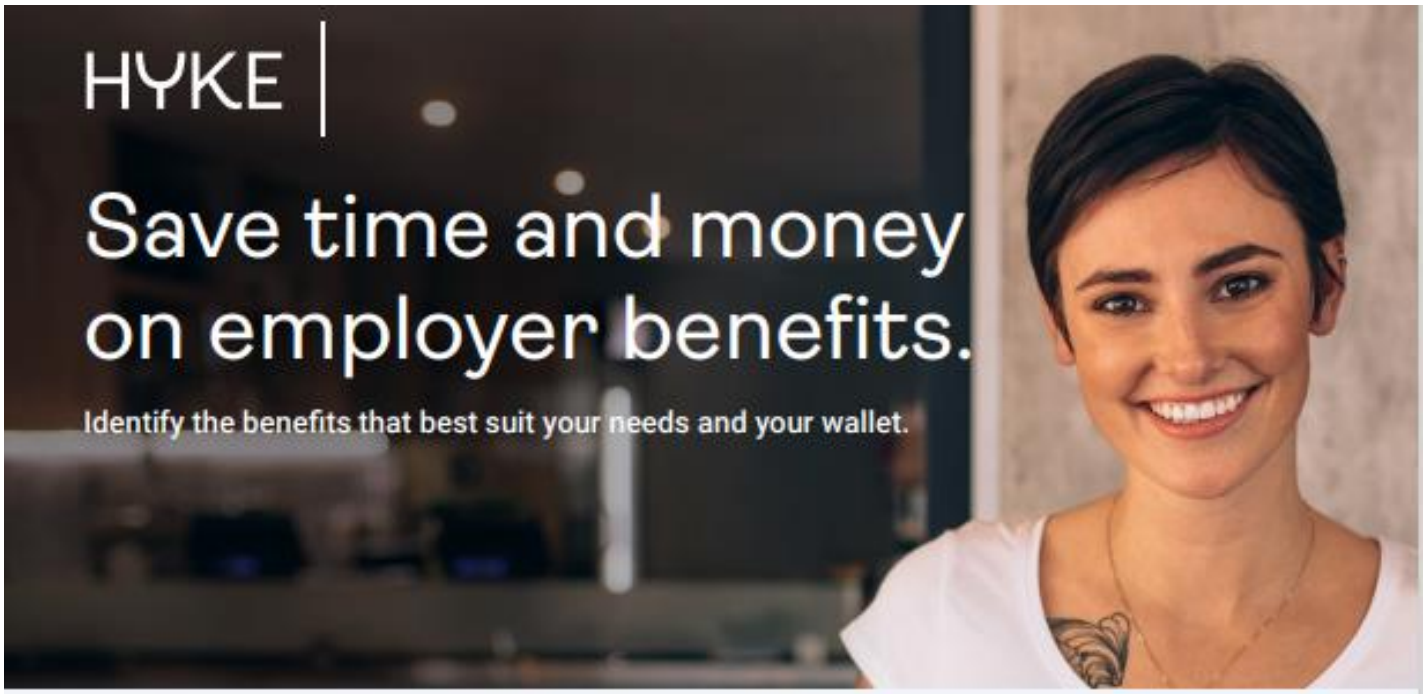
How do I sign up?

Paycom

Available as an app for iOs and Android

- Go to www.paycom.com and click "Employee."
- Log in with your username, password and the last four digits of your social security number.
- Click the button for "2025 Benefit Enrollment" (It is under "My Benefits" in the center of the screen, or on the left side of the page)
- Follow the steps and click "Complete Enrollment."
- Once you are ready to submit, click "Sign and Submit."

Enrollment Decision Support – HYKE



Make HYKE the first step you take to enroll in benefits. This free, fast, and confidential tool is the easiest way to make sure you choose the benefits that work best for you, maximizing your health and financial protection.

Benefits are easy to understand:

- Simple health, financial, and lifestyle information you provide steers HYKE recommendations, matching your needs to the benefits offered
- Understand the value and financial impacts of different benefits scenarios
- Detailed information, videos, and interactive chat are available throughout the HYKE experience

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PERSONAL PROTECTION SCORE

See how well you're covered and get personalized tips to boost your coverage based on what you need and the benefits available.

myhyke.com/noah

When does my coverage start?

Can I make changes after I sign up?

After you've signed up, you can only make changes to your benefits if you have what's called a qualifying life event (QLE). A QLE is something that happens to you or someone in your family. The list of QLEs is defined by the federal government. Some examples are:

- Marriage, divorce, or legal separation
- Birth or adoption of a child.
- Death of a dependent
- You or your spouse lose or gain coverage through our organization or another employer.
- Medicare or Medicaid enrollment
- A special enrollment opportunity to sign up for a plan in the Public Health Insurance Marketplace (i.e. Covered California or another state-run marketplace or Healthcare.gov)

These are just some examples. You can find a complete explanation of qualifying life event changes in the NOAH's section 125 document that reflects employer's permitted status change events (e.g. section 125 document)."

You might be able to add or drop coverage if one or more of these things happen to your family after you sign up. Most Qualified Life Event changes, such as getting married or having a baby, are time-sensitive and must be addressed within 30 days. Alternatively, if you lost eligibility or enrolled in Medicaid, Medicare, or state health insurance programs, you have to submit the request for change within 60 days. It's always a good idea to reach out to your plan administrator or email NOAH's Benefit Team at benefits@noahhelps.org to find out if you can make changes.

Do I have to sign up?

No. You can "waive" medical/dental/and/or vision coverage if you're covered through another plan, such as a plan offered through your spouse's job. Keep in mind that if you waive coverage, you won't be able to enroll in our group benefits again until next year in January 1, 2026, unless you experience a qualifying life event.

If you don't sign up for any health insurance coverage at all, you might have to pay a penalty. Although the federal penalty requiring individuals to maintain health coverage was reduced to $0, some states have their own mandates.

To avoid paying these penalties in certain states, you can sign up for health insurance through our benefits program or purchase coverage from somewhere else, such as from a State or Federal Health Insurance Exchange.

Curious about Healthcare Reform and the Individual Mandate? Reach out to Human Resources or visit www.healthcare.gov.

Medical Plans

Medical Plans

Breaking down plan types (and understanding acronyms)

PPO

On a Preferred Provider Organization plan or PPO, you have more flexibility to choose your providers. However, you'll save the most money when you choose a provider or hospital inside the health plan's network. You may choose a provider who is not in the health plan's network, but it might cost more.

Advantages

- Choose from more providers.
- You will not need a referral to see a specialist.

Out-of-pocket costs

Your health plan can charge different fees such as a flat fee called a "copay," a fee that's a percentage of the total cost of the service, called "coinsurance", and an amount that must be paid before your plan kicks in, called a "deductible." On a PPO plan, you will still be responsible for these types of fees.

Ideal if...

...you want flexibility and provider options. You are comfortable paying more out of your paycheck each month, while paying less out of pocket for your deductible.

Note:

You may choose your health care providers, but keep in mind that you might have to pay more for services that are outside your health plan's network.

Using a PPO plan:

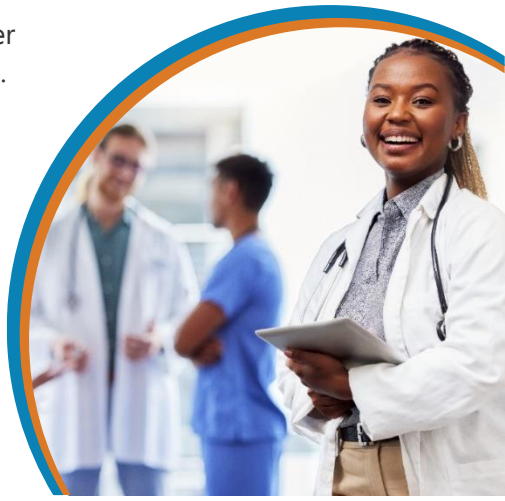
Syd was experiencing a lot of anxiety and wanted to see a psychiatrist. Syd went to the insurance company website and located an in-network provider. Syd paid a set copay after visiting the psychiatrist. The psychiatrist prescribed a generic medication and Syd had a copay for that as well. Both payments count toward Syd's out of pocket maximum.

The PPO plan was the best choice for Syd because planning for regular specialist visits was important. By choosing the PPO, Syd saved money by selecting an in-network provider and got great care.

To find a provider in your PPO plan's network:

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" or "2025" 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



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

HDHP

On a High-Deductible Health Plan (HDHP), you have to pay more out-of-pocket before your health plan starts covering services. The amount you have to pay before the plan kicks in is called the "deductible." To help cover these expenses, you can access a special savings account called a "Health Savings Account (HSA)." You can contribute pre-tax funds to this account and use it to pay for different health-related expenses called "qualified medical expenses."

Advantages

- Your HSA can help you save on taxes.
- The amount taken out of your paycheck is lower.

Out-of-pocket costs

If you choose an HDHP, you will pay most of your out-of-pocket expenses upfront until you reach your deductible.

Ideal if…

…you do not usually need much health care throughout the year and have enough money set aside to cover expenses until you reach your deductible.

Note:

You can only use your HSA funds to pay for qualified medical expenses, such as copay fees and purchases of over-the-counter medications. It is a good idea to keep your receipts in case your taxes are audited.

Using an HDHP plan:

Taylor rarely 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 urgent care clinic for treatment. Because Taylor hadn't yet met the plan's annual deductible, she used funds from her Health Savings Account (HSA) to pay for the visit.

Taylor had savings set aside after choosing to pay less in monthly premiums, so this visit wasn't a big deal. Taylor paid a coinsurance, which counts toward the plan's annual deductible.

To find a provider in your HDHP's network:

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" or "2025" 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

Neighborhood Outreach Access to Health

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

Pharmacy Benefit Manager – MedOne Pharmacy Solutions

Your pharmacy benefits are through MedOne Pharmacy Solutions, effective 01/01/2025. Your Medical ID card from AmeriBen will include RX claim information. Please present your card at the pharmacy whenever you fill a prescription.

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

- The MedOne 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 MedOne's Performance 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!

Specialty Medications Pharmacy – MedOne Pharmacy Solutions

Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring. Ordering new prescriptions through our specialty pharmacy, MedOne Pharmacy Solutions Services is simple. Just call a patient care specialist at 1.866.335.9057 to get started. They will work with you and your prescriber to fill your prescription. The MedOne team will call and verify your information and review medication details.

Mail Order Pharmacy - MedOne Pharmacy Solutions

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 MedOne Pharmacy Solutions, register online at https://my.medone-rx.com. For a current version of the prescription drug list(s) or get help with your RX benefit questions, go to https://my.medone-rx.com or call 1.866.335.9057. MedOne Customer Care is available 24 hours a day, 7 days a week.

To register and login to the member portal, please visit MedOne' s portal at https://my.medone-rx.com. If you are a first-time user, you must register for an account.

If you have questions, you can contact customer care 24/7. They can be reached at 866-335-9057.

Saving money on your medications

Your benefits cover a lot of prescription medications, but how much you pay for them, and how much your health plan covers, is determined by a system of "tiers." These tiers are more like a layer cake than a rating system: The quality is the same no matter where you are, but the higher you go on these tiers, the more expensive and/or hard to access the medication may be.

Here are some examples of the types of medications in each tier:

$

Tier 1 - Generic Formulary:

These medications have the same active ingredients as brand-name medications, but they cost less.

$$

Tier 2 - Brand name:

These medications are only made by one manufacturer. They're proven to be the most effective medications in their class. The NOAH Pharmacy is called Performance Formulary List.

$$$

Tier 3 - Non-formulary:

Medications that aren't on your health plan's list of preferred medications, which is called their "formulary." Usually, this happens when there is a safe and effective alternative that is less expensive—often a generic. If your doctor prescribes a non-formulary prescription, it's a good idea to speak with them or your pharmacist about generic alternatives.

$$$$

Tier 4 - Specialty:

These medications treat chronic or complex conditions. They might require special storage or careful monitoring.

Why pay more for your medications?

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Utilize NOAH Pharmacies

Save time and money by utilizing NOAH pharmacies. NOAH pharmacies offer the lowest cost for scripts over other in-network pharmacies. It is a convenient and cost saving way to fill your prescriptions. Did you know NOAH is also able to fill your specialty medications?

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.

Need to reach a provider right away?

Telehealth services

Video chat for work, for school, for violin lessons, for…your sore throat? Yes! That miraculous little device in your hand can connect with a doctor for a video or voice chat. You can also use your desktop computer! These virtual visits save time and effort.

If your provider recommends a prescription medication during your virtual visit, Teladoc will send it to a local pharmacy.

It's affordable, too. Through Teladoc, telehealth services 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: $57
- Dermatology: $89 consultation fee
- Behavioral Health e-visits are based on providers specialty and type of e-visit
- Psychiatry: $230 Initial visit/$104 ongoing
- Psychology/Therapy: $94

The dependents on your health plan can use it, too. Video visits for all!

Start your telehealth visit:

- By phone: 1.800.835.2362
- Online: www.teladoc.com
- Download Teladoc's mobile app.

"How much will specific services cost?"

Plan Highlights	Base Plan		Buy-up	
	In-network NOAH Providers	In-network BCBSAZ Network	In-network NOAH Providers	In-network BCBSAZ Network
Annual Calendar Year Deductible				
Individual	$6,000		$1,000	
Family	$12,000		$2,000	
Maximum Calendar Year Out-of-pocket [1]				
Individual	$6,450		$5,000	
Family	$12,900		$10,000	
Professional Services				
Primary Care Physician (PCP)	$5 copay	$40 copay	$5 copay	$35 copay
Specialist	N/A	$75 copay	N/A	$70 copay
Telehealth Visit	$5 copay	$20 copay	$5 copay	$20 copay
Preventive Care Exam	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Diagnostic X-ray and Lab	N/A	$40 copay	N/A	$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	$75 copay	N/A	$70 copay
Emergency Room	N/A	$350 copay	N/A	$250 copay
Mental Health & Substance Abuse				
Inpatient	N/A	20% after ded	N/A	20% after ded
Outpatient Surgery	N/A	20% after ded	N/A	20% after ded
Outpatient Other Outpatient Services	$5 copay 10% after ded	$40 copay 20% after ded	$5 copay 10% after ded	$35 copay 20% after ded
Retail Prescription Drugs (30-day supply)				
Preventive Medications	No Charge, Deductible waived		No Charge, Deductible waived	
Tier 1	$5 copay	$10 copay	$5 copay	$10 copay
Tier 2	$10 copay	$20 copay	$10 copay	$20 copay
Tier 3	$25 copay	$50 copay	$25 copay	$50 copay
Tier 4	$125 copay	$250 copay	$125 copay	$250 copay
Mail Order Prescription Drugs (90-day supply)				
Preventive 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	

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.25

"How much will specific services cost?"

Plan Highlights — Health Savings Account Plan (HDHP)

	In-network NOAH Providers	In-network BCBSAZ Network
Annual Calendar Year Deductible		
Individual	$3,300	
Family	$6,600	
Maximum Calendar Year Out-of-pocket [1]		
Individual	$6,450	
Family	$12,900	
Professional Services		
Primary Care Physician (PCP)	10% after deductible	20% after deductible
Specialist	N/A	20% after deductible
Telehealth Visit	10% after deductible	20% after deductible
Preventive Care Exam	Plan Pays 100%	Plan Pays 100%
Diagnostic X-ray and Lab	N/A	20% after deductible
Complex Diagnostics (MRI/CT scan)	N/A	20% after deductible
Hospital Services		
Inpatient	N/A	20% after deductible
Outpatient Surgery	N/A	20% after deductible
Urgent Care	N/A	20% after deductible
Emergency Room	N/A	20% after deductible
Mental Health & Substance Abuse		
Inpatient	N/A	20% after deductible
Outpatient	10% after deductible	20% after deductible
Other Outpatient Services	10% after deductible	20% after deductible
Retail Prescription Drugs (30-day supply)		
Preventive Maintenance Medications	No Charge, deductible waived	No Charge, deductible waived
Tier 1	$5 copay after deductible	$10 copay after deductible
Tier 2	$10 copay after deductible	$20 copay after deductible
Tier 3	$25 copay after deductible	$50 copay after deductible
Tier 4	$125 copay after deductible	$250 copay after deductible
Retail (90-day supply) Prescription Drugs		
Preventive Medications	No Charge, deductible waived	No Charge, deductible waived
Tier 1	$13 copay after deductible	$25 copay after deductible
Tier 2	$25 copay after deductible	$50 copay after deductible
Tier 3	$63 copay after deductible	$125 copay after deductible
Mail Order Prescription Drugs (90-day supply)		
Preventive Medications	No Charge, deductible waived	No Charge, deductible waived
Tier 1	$25 copay after deductible	
Tier 2	$50 copay after deductible	
Tier 3	$125 copay after deductible	

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

Medical Cost Breakdown

The rates below are effective January 1, 2025 – December 31, 2025.

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	$30.79	$79.96
Employee and Spouse/Domestic Partner	$103.28	$258.20
Employee and Child(ren)	$89.57	$223.93
Employee and Family	$193.70	$435.81
AmeriBen - Buy-Up PPO Plan		
Employee Only	$94.30	$235.75
Employee and Spouse/Domestic Partner	$270.97	$677.43
Employee and Child(ren)	$206.91	$517.26
Employee and Family	$449.05	$1010.36
AmeriBen – High Deductible Health Plan		
Employee Only	$50.74	$126.85
Employee and Spouse/Domestic Partner	$149.12	$372.79
Employee and Child(ren)	$110.53	$276.33
Employee and Family	$271.65	$611.21

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/

Spending Accounts

Spending Accounts

Make your money work for you

Health Savings Account (HSA)

When you sign up for a NOAH's High-Deductible Health Plan (HDHP), you can open a type of bank account called a Health Savings Account (HSA). This account allows you to save money for qualified health care expenses, such as your deductible, copayments, and other out-of-pocket expenses. The money you put in your HSA is not federally taxed.

Learn more about Health Savings Accounts:

[What is a Health Savings Account (HSA)? - The Ultimate Guide | Lively (livelyme.com)]

What to know about your health savings account

It's all yours—you own your HSA, and your funds can accumulate year after year

You choose how much to contribute up to an annual maximum.

You have to be enrolled in a High-Deductible Health Plan in order to contribute.

HSA funds are not taxed as long as you use the funds for qualified expenses.

HSA Facts

What are the benefits?	• HSA funds aren't taxed and can continue to grow tax-free, subject to state law. Talk to your tax advisor to find out what applies in your state. • An HSA reduces your taxable income, so it may allow you to pay for qualified health care expenses tax-free. Just remember that tax regulations vary by state. • HSAs are paired with HDHPs. HDHPs cost less each month in premiums compared to PPO plans. • Your employer contributes free money to your HSA. NOAH contributes $960 to your HSA if you are enrolled in an employee-only HDHP coverage, and $1,920 if you are enrolled in family HDHP coverage. To get the funds, make sure to let your employer know you've opened an HSA, and keep it open so you can get their contributions. If you don't follow these steps, you could forfeit your contribution. NOAH'S contributions will be determined by how many months you've been enrolled in their HDHP.
How do I become eligible to contribute to an HSA?	• You're eligible if you enrolled in an HDHP. There are a few other rules to keep in mind, as well. You can't be enrolled in non-qualified health insurance outside of NOAH's plan or in Medicare, can't be claimed as a dependent on someone else's tax return (excluding a spouse), can't get any hospital care or medical services from the Veterans Administration in the previous three months (unless these services were related to a service-connected disability) and can't be enrolled in a general Healthcare Flexible Spending Account (Health FSA) or a general Health Reimbursement Arrangement (HRA).
How do I get started?	• If you're ready to activate your HSA: – Step 1. Enroll in NOAH's High Deductible Health Plan (HDHP) – Step 2: Enroll in Health Savings Account with Lively. • Once the HSA is activated, you can manage and access your account at any time by visiting https://secure.livelyme.com/login. For questions about account activation, contact Lively or visit https://secure.livelyme.com/login. • When you want to make a qualified purchase, the most convenient way is by using your HSA debit card. You can also use your own cash or a personal credit card and reimburse yourself through your online HSA. Just make sure to keep your receipts—they'll be important if you ever get audited by the Internal Revenue Service (IRS). Consult your tax advisor for taxation information or advice.
few rules to keep in mind…	• For 2025, the maximum that you and your employer together can contribute to your HSA account is $4,300 if you are enrolled in the HDHP for employee-only coverage. If you're enrolled in a plan with dependents, the maximum is $8,550. There is a $1,000 catch up for those employees aged 55 and older. This maximum is set by the IRS, and it's important that you don't go over it. • If you go over the IRS limit, the amount you go over will be taxed at standard income tax rates, plus a 6% excise tax. • If you use your HSA funds to pay for non-qualified expenses, you'll pay taxes on the funds as well as a 20% penalty (unless you are over age 65). Once you reach age 65, you can use your hoarded cash however you want. You can find more info about qualified health care expenses at https://secure.livelyme.com/login. • Typically, the amount you can contribute to your HSA in a calendar year is pro-rated based on when you became eligible. So, if you become HSA-eligible on September 1st, you can only contribute ⅓ of the maximum annual limit during your first year of enrollment. However, under the • Full-Contribution Rule, you can still contribute up to the annual maximum. as long as: • You're HSA-eligible on Dec. 1 of the plan year, and • You're still HSA-eligible through Dec. 31 of the following year

Flexible Spending Account (FSA)

With this type of account, you and your spouse, plus any eligible dependents, can use pre-tax dollars to cover health care or dependent care. There are different types of FSAs, but they all help reduce your taxable income. Here are the different types of FSAs.

FSA Type		Detail
	**Healthcare FSA**	• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance. • Maximum contribution for 2025 is $3,300.
	**Limited Purpose FSA**	• Employees may want to consider a limited purpose FSA if they are HSA eligible and plan to contribute to an HSA during the plan year. • This FSA may be used to reimburse qualified preventive care, dental, and vision expenses. • Maximum contribution for 2025 is $3,300.
	**Dependent Care FSA**	• Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Eligibility rules require that if you are married, your spouse needs to be working, looking for work or attending school full-time. • Maximum contribution for 2025 is $5,000.

To learn more: [What is an FSA? - Your Guide to Flexible Spending Accounts | Lively (livelyme.com)]

Questions about your FSA? Reach out to Human Resources at benefits@noahhelps.org

How to use your FSA

Estimate how much you'll need to cover with FSA funds this year.

Set up annual (pre-tax) deductions from your paycheck.

Use your FSA debit card for purchases made on your own behalf.

You can roll up to $660 of FSA funds over to the next year, after all your qualified expenses are reimbursed at the end of the current plan year.

Supplemental Health Plans

Supplemental Health Plans

Prepare for the unexpected twists and turns.

Critical Illness Insurance

If you choose to sign up for this coverage, UNUM will pay you a lump sum of money if you're diagnosed with a specific critical illness.

This type of coverage pays you directly in cash, so you can use the funds however you want. Here are a few examples:

- Medical expenses
- Lost income
- Everyday expenses such as groceries and utilities
- Alternative treatments
- Lodging and travel to see specialists
- $50 Be Well Benefit

100% employee-paid

Some covered illnesses:

- Cancer
- Heart Attack
- Stroke
- Alzheimer's
- Kidney Failure (ESRD)
- Organ Transplant

Your employer doesn't cover any part of this optional benefit. If you choose to sign up, the cost of coverage will be deducted from your paycheck. Monthly post-tax rates are outlined below:

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

Want to learn more?

For more info, visit www.unum.com.

Hospital Insurance

Hospital stays are difficult, especially if your health plan doesn't cover costs. To help ensure you can afford a hospital stay, you can sign up for hospital insurance through UNUM. This benefit will pay cash to you or your family to offset medical and non-medical bills that you get after staying in the hospital.

What can hospital insurance pay for?

This type of coverage pays you directly in cash, so you can use the funds however you want. Here are a few examples:

- Copayments
- Deductibles
- Transportation expenses
- Childcare
- Lodging expenses for a companion
- Lost income
- Be Well Benefit - $50

100% employee-paid

Your employer doesn't cover any part of this optional benefit. If you choose to sign up, the cost of coverage will be deducted from your paycheck. Monthly post-tax rates are outlined below:

Election	Per Pay Period Contribution
Employee Only	$7.94
Employee + Spouse	$13.25
Employee + Child(ren)	$11.34
Family	$16.65

Using hospital insurance: an example

Morgan needed gallbladder removal surgery, and due to some complications, had to stay in the hospital for five days. Morgan has health insurance, but it didn't cover the full cost of the stay. Morgan's health plan required she pay the deductible and a co-insurance fee. Hospital insurance helped make up the difference. It paid a set amount for an admission benefit plus a set amount for each additional day. This helped reduce Morgan's cost for her stay.

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

Want to learn more?

For more info, visit www.unum.com.

Accident Insurance

We all know they happen, but not everyone is prepared. Accident insurance is optional coverage that helps you pay for expenses if something unexpected occurs. The benefits are paid directly to you to help cover specific treatments, and the amount depends on the type of injury you have and what care you need.

What can accident insurance pay for?

This type of coverage pays you directly in cash, so you can use the funds however you want. You could use the funds to pay for:

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

100% employee-paid

Your employer doesn't cover any part of this optional benefit. If you choose to sign up, the cost of coverage will be deducted from your paycheck. Monthly post-tax rates are outlined below:

Election	Per Pay period Contribution
Employee Only	$6.74
Employee + Spouse	$11.89
Employee + Child(ren)	$13.91
Family	$19.06

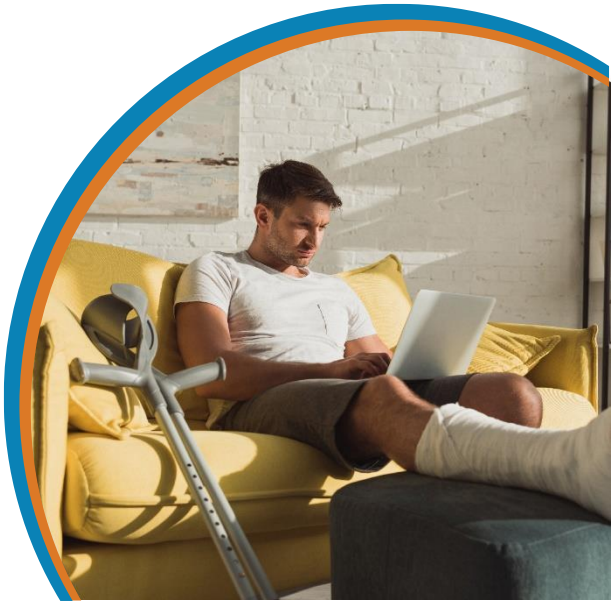
Using accident insurance: an example

Sam was involved in a car accident and needed physical therapy. The treatment was intense, so Sam couldn't work during recovery. Sam's accident insurance policy provided payments that Sam could use towards things such as the out-of-pocket costs of treatment, monthly mortgage payments, or daycare fees. Accident insurance helped Sam focus on recovery instead of worrying about how to pay for it.

Covered Event/Injury	Benefit Amount
Ambulance (ground)	$300
Emergency room care	$100
Physician follow-up ($75 x 2)	$150
X-ray	$50
Concussion	$200
Broken tooth (repaired by crown)	$350
Total benefit paid by Sam's Accident Plan	$1,150

Want to learn more?

For more info, visit www.unum.com



Dental Plans

Dental Plan PPO

Taking care of your smile

With the Dental PPO plan, you can pick any licensed dentist. Just keep in mind that your dental plan has settled on lower rates with a smaller group of providers—those in their network. If you choose a dentist outside that network for yourself or your dependents, you might have to pay more.

To find out if your dentist is in your provider network, you can search on www.deltadentalaz.com or calling Delta Dental of AZ at 800-352-6132, Option 1.

"How much will specific services cost?"

Plan Highlights	Delta Dental Base PPO		Delta Dental Buy-up PPO	
	In-network Delta Dental	**Out-of-network**	**In-network Delta Dental Premier**	**Out-of-network**
Calendar Year Deductible				
Individual	$50		$50	
Family	$150		$150	
Annual Maximum	$1,500		$2,000	
Preventive	0%	20%	0%	20%
Basic Services	20%	50%	20%	50%
Major Services	50%	Not Covered	50%	50%
Orthodontia Services	Not covered	Not covered		
Adults	N/A	N/A	50%	
Children to age 26	N/A	N/A	50%	
Lifetime Maximum	N/A	N/A	$2,500	

Plan Highlights	Delta Dental Enhanced PPO	
	In-network Delta Dental	**Out-of-network**
Calendar Year Deductible		
Individual	$50	
Family	$150	
Annual Maximum	$2,000	
Preventive	0%	20%
Basic Services	20%	50%
Major Services	50%	50%
Orthodontia Services	Not Covered	
Adults	N/A	
Children to age 26	N/A	
Lifetime Maximum	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.

Dental Cost Breakdown

The rates below are effective January 1, 2025 – December 31, 2025.

Coverage Level	Semi-Monthly (24 Pay Period Deductions)	Semi-Monthly (24 Pay Period Deductions)
	Full-Time Employee	**Part-Time Employee**
Delta Dental – Base Plan		
Employee Only	$6.43	$9.64
Employee and Spouse/Domestic Partner	$14.29	$17.38
Employee and Child(ren)	$17.10	$22.08
Employee and Family	$27.83	$33.34
Delta Dental – Buy-up Plan		
Employee Only	$10.91	$16.36
Employee and Spouse/Domestic Partner	$29.51	$31.25
Employee and Child(ren)	$33.58	$37.07
Employee and Family	$43.16	$43.16
Delta Dental – Enhanced Plan		
Employee Only	$23.20	$22.70
Employee and Spouse/Domestic Partner	$64.79	$64.79
Employee and Child(ren)	$78.64	$78.64
Employee and Family	$112.23	$112.23

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 Plans

Vision Plans

Bringing your benefits into focus

VSP Vision Care offers vision coverage as a Preferred Provider Organization (PPO) plan. With the vision plan, you can pick where to receive services. Just keep in mind that your vision plan has settled on lower rates with a smaller group of vision providers—those in their network. If you choose a vision provider outside that network for yourself or your dependents, you will have to pay for all the expenses yourself at the time of service. Then, you'll submit a claim, and VSP Vision Care will reimburse you up to a certain "allowed" amount.

To find out if a vision provider is in your network, you can search on www.vsp.com or calling VSP Vision Care.

"How much will specific services cost?"

Plan Highlights	VSP Vision PPO	
	In-network VSP Network	**Out-of-network**
Exam – Every 12 months	$10 copay	Reimbursed up to $45
Lenses – Every 12 months	$30 copay	N/A
Single	Covered in Full after $30 copay	Reimbursed up to $30
Bifocal	Covered in Full after $30 copay	Reimbursed up to $50
Trifocal	Covered in Full after $30 copay	Reimbursed up to $65
Frames – Every 12 months	$150 frame allowance. If frames exceed $150, an additional 20% of the excess amount is 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
LASIK	Average savings of 15-20% off retail price or 5% off promotional price	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.

Vision Cost Breakdown

The rates below are effective January 1, 2025 – December 31, 2025.

Coverage Level	Semi-Monthly (24 Pay Period Deductions)	Semi-Monthly (24 Pay Period Deductions)
	Full-Time Employee	**Part-Time Employee**
VSP Vision Plan		
Employee Only	$3.93	$3.93
Employee and Spouse/Domestic Partner	$6.29	$6.29
Employee and Child(ren)	$6.42	$6.42
Employee and Family	$10.35	$10.35

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Life & Disability

Life & Disability

Life Insurance and AD&D

There's no easy way to talk about death, but your family might need help if something happens to you. A life and accidental death and dismemberment (AD&D) policy can provide that help. You are automatically signed up for this benefit and your family will be paid a lump sum of money when you die. If your death was caused by an accident, or if you lose a limb, you or the people you choose, called "beneficiaries," may get additional coverage.

NOAH pays for 100% of this benefit through UNUM. It includes the following:

For all Full & Part-Time Active Employees who are Physicians, Directors, Managers, NPs, Pas, Residents, Foundation VPs, and Associate VPs:

- Basic Life Insurance & matching AD&D Insurance: 2x annual earnings up to $400,000

For all Full & Part-Time Active Employees working a minimum of 17 hours per week who are not covered in another group:

- Basic Life Insurance & matching AD&D Insurance: 1x annual earnings up to $200,000

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

Quick note on IRS Regulations: You can receive employer-paid life insurance coverage up to $50,000 on a tax-free basis and do not have to report the payment as income. However, coverage of more than $50,000 will trigger taxable income for the "economic value" of the coverage provided to you.

Voluntary Life and AD&D

You can choose to add more life insurance and AD&D coverage for you and/or your dependents. These can be taken out of your regular paycheck by UNUM. Here are details on the additional coverage amounts you can choose from:

	**For employees:**	• Increments of $10,000 not to exceed 5x annual earnings or $500,000, whichever is less, with a guaranteed 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 a $250.000 maximum with a guaranteed issue benefit of $50.000 if you enroll in the plan within 30 days of your initial eligibility. Benefit is not to exceed 100% of the employee elected and approved voluntary life amount.
	**For your child(ren):**	• Live birth up to 6 months of age, $1,000; 6 months old up to age 26 years of age, increments of $2,000 to a maximum of $10,000.
	**Optional AD&D:**	• Coverage is available for purchase in the same amounts as optional 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 turn 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Take a look at your Summary Plan Description for exclusions and further detail.

Don't forget to update your beneficiaries!

The people or entities who you want to receive benefits from your policy are called beneficiaries. It's very important that they are up to date.

- You may change your beneficiaries at any time.
- You may designate one person as your beneficiary or choose multiple beneficiaries, who will each get a percentage of the payout amount.
- To select or change your beneficiary, login to Paycom and update your beneficiary or contact Unum.

Voluntary Life and AD&D Cost Breakdown

The rates below are effective January 1, 2025 – December 31, 2025.

Cost of Employee Voluntary Coverage		Cost of Spousal Voluntary Coverage		Dependent Child Coverage	
Age of Insured	**Monthly Rate per $1,000**	**Age of Insured**	**Monthly Rate per $1,000**	**Benefit Amount**	**Monthly Premium**
15–24	$0.020	15–24	$0.020	Composite	
25–29	$0.020	25–29	$0.020	Per $1,000	$0.428
30–34	$0.030	30–34	$0.030		
35–39	$0.050	35–39	$0.050		
40–44	$0.070	40–44	$0.070		
45–49	$0.110	45–49	$0.110		
50–54	$0.170	50–54	$0.170		
55–59	$0.240	55–59	$0.240		
60–64	$0.290	60–64	$0.290		
65–69	$0.390	65–69	$0.390		
70–74	$0.710	70–74	$0.710		
75+	$2.390	75+	$2.390		
AD&D	**$0.025**	**AD&D**	**$0.025**	**AD&D**	**$0.100**

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/

Disability Insurance

When you're too sick or injured to work, you need time to focus on healing—not worrying about your income. Enrolling in disability insurance offers you and your family peace of mind by helping to replace some of your income if you have a non-work-related illness or injury. Your eligibility may be based on disability for your occupation or any occupation.

Your Plans	Coverage Details
Short Term Disability (STD)	• Administered by UNUM, STD coverage provides a benefit equal to 60% of your weekly earnings, up to $2,500 per week for a 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.
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.

Note: Please note, the state you reside in may provide a partial wage-replacement disability insurance plan.

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.

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Retirement

Retirement

Planning for the future

Your 403(b) Plan

No matter how wonderful your job is, it's good to plan ahead for retirement. A 401(k) plan helps you plan for your future by squirreling away a portion of each paycheck. These funds are withdrawn each pay period and invested so they can grow (subject to federal law and plan guidelines). You can withdraw the funds when you retire.

See Human Resources to confirm whether you're eligible and when you can enroll.

Enrollment & Account Access

- To enroll in the 401(k) plan, please visit https://participant.empower-retirement.com/participant/#/login.
- All retirement elections are made directly through Empowers website.
- Check your 401(k) 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 401(k) Information

Contribution Limits: For 2024, the IRS annual contribution limits are $23,000 for everyone under age 50 or $30,500 for anyone that is age 50 or over prior to December 31, 2024. If you have multiple employers during the year, all your contributions are combined. 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 other. contribution limit. You may also stop contributing any time. Requests to change or stop your contributions must be made through the Empowers website.

Employer Contributions: A discretionary match is offered to all eligible participants of 100% up to 4% of your eligible compensation. Employees are eligible for employer match 90 days after date of hire. 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: You can combine your accounts through something called a "rollover." If you have other qualified retirement plans or account such as a 401(k) from a previous employer, 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: When your employment is terminated, regardless of reason, you can request a full distribution of your vested account balance. You can roll over your account to another qualified plan or IRA without any penalty. You may also request a lump-sum cash payment to yourself but know that might come with tax penalties.

Employee Assistance Program (EAP)

Employee Assistance Program

Free resources for tough moments

Your Employee Assistance Program (EAP) is a set of services that can support you through personal and professional challenges with resources, information, and counseling. Everything is confidential—what you talk about won't be shared with your employer—and free.

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 year per incident (UNUM)
How to access	Phone or face-to-face sessions
Topics may include	Mental Health Support: 24/7/365 – Comprehensive telephonic assessments & consultations – 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 – Calm App 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	You, your dependents, and even other members of your household.

Get in touch Optum:

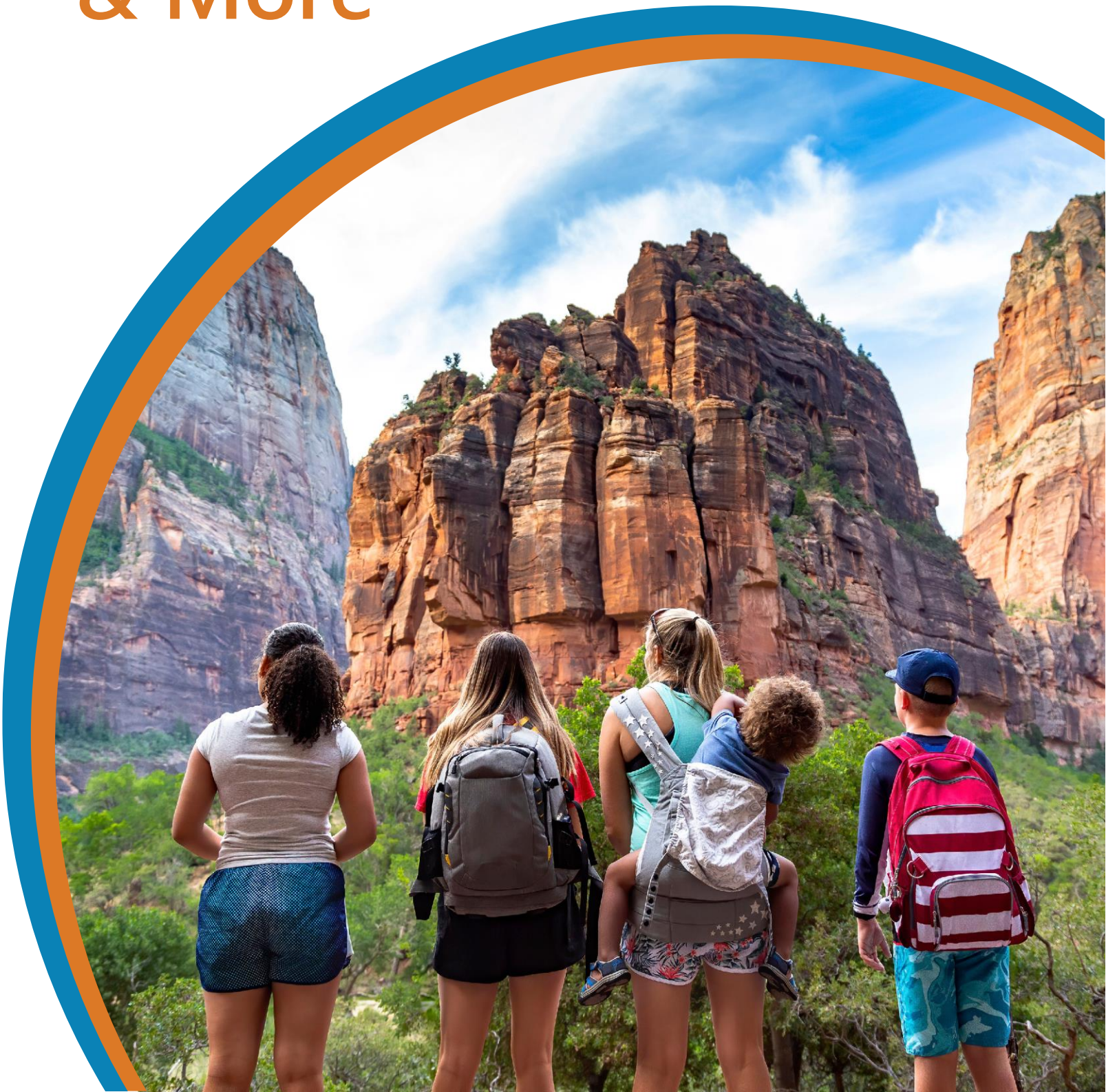
- By Phone: 866.248.4096
- Online: www.liveandworkwell.com
- Website password: NOAH

Get in touch UNUM:

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

Perks

& More



Perks & More

Finally, the fun stuff

Your benefits package isn't all insurance. It still knows how to have fun. In that spirit, your employer gives you these perks.

Holidays

These are our company's paid holidays. Yes, you heard that right - they're paid, but you don't have to work.

The following paid holidays will be observed:

- New Year's Day - January 1, 2025
- Cesar Chavez Day – March 31, 2025
- Memorial Day - May 26, 2025
- Juneteenth - June 19, 2025
- Independence Day - July 4, 2025
- Labor Day - September 1, 2025
- Thanksgiving Day and the day after - November 27 & 28, 2025
- Christmas – December 25, 2025

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

Pet Insurance – United Pet Care

Woof, Meow, Cheep Cheep! That's pet for "Optional pet insurance from United Pet Care can cover your dogs, cats, birds, and some other exotic animals." Plans start at $24.50 per month. You can view your options at www.unitedpetcare.com/enroll If you're having trouble deciding, contact them at 877-872-8800. They'd love to help you choose the best plan for your best friend.

Identity Theft - Allstate

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.

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 – MetLife 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**

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

Directory & Resources

Directory & Resources

Below, please find important contact information and resources for NOAH.

Information Regarding	Policy #	Contact Information	
Enrollment & Eligibility			
Human Resources: Kat Bergman / HR Benefits Manager Online Enrollment Vendor: Paycom	N/A	480.882.4545	kabergman@noahhelps.org www.paycom.com
Medical Coverage			
Ameriben • BASE • Buyup • HDHP	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			
MedOne Pharmacy Solutions	BIN: 024624 PCN: MDI Rx Group Code: AMRBNNOAHX	866.335.9057	WWW.MEDONE-RX.COM
Dental Coverage			
Delta Dental of AZ • Base • Buy-up • Enhanced	1003	800.352.6132 Option 1	www.deltadentalaz.com or email customerservice@deltadentalaz.com
Vision Coverage			
Vision Service Plan Vision PPO	30107133	800.352.6132 Option 1	www.vsp.com
Life, AD&D, Disability, Supplemental			
Unum • Basic Life & AD&D • Voluntary Life & AD&D • Short- & Long-Term Disability • Accident Insurance • Critical Illness Insurance • Hospital Indemnity	 946399 946400 946399 946402 946401 946403	866.679.3054	www.unum.com
Flexible Spending Accounts			
Lively	NOAH	888.576.4837	www.livelyme.com
Health Savings Account			
Lively	NOAH	888.576.4837	www.livelyme.com
403(b) Retirement Plan Adviser			
Empower	NOAH	855.756.4738	https://participant.empower-retirement.com
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	portal.allstateidentityprotection.com/signin/
Legal Service			
	5392558	800.821.6400	www.legalplans.com
Benefits Broker			
Marsh & McLennan Insurance Agency Barb Elcess Shan O'Connor	 Sr. Client Manager Claim Advocate	 520.722.7104 602.385.7069	 Barb.Elcess@MarshMMA.com Shan.O'Connor@MarshMMA.com

Thanks for Reading

This guide contains just a few (or a few more than a few) words about your benefits, but it represents a network of resources and support. Now it's time to get back to living—knowing that this guide is here when and if you ever need it. If questions slow you down, keep in mind that the NOAH HR Team would be happy to help. Here's to a happy, healthy year ahead!

MEDICARE PART D

CREDITABLE COVERAGE NOTICE

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

PPO $1,000	**Creditable**
PPO $6,000	**Creditable**

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 Health 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 Health has determined that the prescription drug coverage offered by the Neighborhood Outreach Access to Health 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 Health coverage as an active employee, please note that your Neighborhood Outreach Access to Health 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 Health coverage as a former employee.

You may also choose to drop your Neighborhood Outreach Access to Health coverage. If you do decide to join a Medicare drug plan and drop your current Neighborhood Outreach Access to Health 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 Health 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 Health 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).

Neighborhood Outreach Access to Health
Tera Brulotte-Maki / Director of Human Resources
7500 N. Dreamy Draw Dr, Suite 145, Phoenix, AZ 85020
509-714-2476

MEDICARE PART D
NON-CREDITABLE COVERAGE NOTICE

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

HDHP $3,300	Non-Creditable

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 Health 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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 Health has determined that the prescription drug coverage offered by the Neighborhood Outreach Access to Health is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Neighborhood Outreach Access to Health. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**
3. **You can keep your current coverage from Neighborhood Outreach Access to Health. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much**

you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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.

Since you are losing creditable prescription drug coverage under the **Neighborhood Outreach Access to Health**, you are also 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 Health, coverage as an active employee, please note that your Neighborhood Outreach Access to Health 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 Health coverage as a former employee.

You may also choose to drop your Neighborhood Outreach Access to Health coverage. If you do decide to join a Medicare drug plan and drop your current Neighborhood Outreach Access to Health 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?

Since the coverage under Neighborhood Outreach Access to Health is not creditable, you may pay a penalty to join a Medicare drug plan depending on how long you go without creditable prescription drug coverage. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (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 will 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 Health 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).

01/01/2025
Neighborhood Outreach Access to Health
Tera Brulotte-Maki / Director of Human Resources
7500 N. Dreamy Draw Dr, Suite 145, Phoenix, AZ 85020
509-714-2476

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Neighborhood Outreach Access to Health 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 480.882.4545.

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 Health (“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 Health
Attention: HIPAA Privacy Officer
7500 N. Dreamy Draw Dr, Suite 145,
Phoenix, AZ 85020
480.882.4545

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 July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremiumassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program| Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/

	Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, 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 Human Resources at benefits@noahhelps.org

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;
- 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: Human Resources Benefit Team at benefits@noahhelps.org

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 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

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

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.
Human Resources Benefit Team at benefits@noahhelps.org

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:

1. 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.

2. 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.

Notice Regarding Availability of Health Insurance Exchange

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(Expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

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 is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1] [2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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.

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 480.882.4545
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 midyear, 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