benefits

NORTH COUNTRY HealthCare

2025 Information guide

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 on the Benefits pages of ASPEN or by contacting Human Resources. 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 43 for more details.

Check out your benefits

Dig into options, programs, and resources

Fixed Indemnity Policy Notice
Mutual of Omaha – 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

Who can Enroll?

Some part-time and all full-time employees are eligible for benefits. If you are an employee regularly working 20-29 hours per week, you are considered part-time and are eligible to participate in the benefits program. If you are an employee regularly working a minimum of 30 hours per week, you are considered full-time and are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/ domestic partner and/or eligible children.

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

When Does Coverage Begin?

Benefit Eligible Employees are effective on your date of hire.

Your enrollment choices remain in effect through the end of the benefits plan year, January 1, 2025 – December 31, 2025.

TIP

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

How do I Enroll?

Datis e3

To enroll, simply follow these steps:

- Log on at https://ess.datis.com/e3/Home/LoginPage.aspx
- Log into Datis e3 using your Employee login credentials, click next.
- To access your enrollment, select Benefit Enrollment or Open Enrollment.

**For assistance, please contact your Human Resource Business Partner.

Benefit Questions?

ALEX is here to Help!

We recommend utilizing the ALEX Benefits Counselor to determine which plans are right for you. Legacy ALEX GO can be used from your mobile device.

Chat, our benefits chatbot powered by ALEX, is available 24/7 to give you answers instantly to all your burning benefits questions.

Chat can assist with:

- Looking up plan details.
- Tracking down account links
- Decoding benefits jargon
- Quick questions after hours (even when the rest of your benefits team is sleeping)

- Benefits Counselor: https://start-review.myalex.com/nchc/?2025
- Legacy Alex Go English: https://start-review.myalex.com/nchc/?2025

Your benefits are effective on your date of hire. New benefit elections are effective on January 1, 2025.

What if My Needs Change During the Year?

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 Required Notices section of this 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 HR Business Partner for your region to find out if you can make changes

Do I Have to Enroll?

This year, we are holding an active enrollment, so all employees must elect or decline benefits. Additionally, because all benefit eligible employees are offered employer-paid benefits such as Life and AD&D insurance, employees are required to ensure that beneficiaries are correctly selected for these plans. 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 October 2025, 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 your Human Resources Business Partner or visit www.cciio.cms.gov.

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 https://ingagedbenefits.com/login and use company code NCHC to log in.

Medical Plans

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. To help cover these expenses, you can access a short-term savings account called "Flexible Spending Account (FSA)." You can contribute pre-tax funds to this account and use it to pay for different health-related expenses called "qualified medical expenses."

Advantages

- Choose from more providers
- You won't 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'll still be responsible for these types of fees.

Ideal if...

...you want flexibility and provider options.

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: an example

Syd was experiencing a lot of anxiety and wanted to see a psychiatrist. Syd went to the insurance company website and located an in-network provider. Syd paid a $25 copay after visiting a North Country Healthcare mental health provider. The provider prescribed a generic medication, which cost Syd a $5 copay at a North Country Healthcare pharmacy. Both payments count toward Syd's $5,000 annual out of pocket maximum amount.

The PPO plan was the best choice for Syd because planning for regular specialist visits was important. That can get expensive with a high-deductible plan. By choosing the PPO, Syd saved money and got great care.

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

Blue Cross Blue Shield of Arizona – National PPO Network

- Visit your health plan's My Health Toolkit site. www.myhealthtoolkitaz.com
- At your health plan's My Health Toolkit member account,
- Select providers and services, then **Find Care.**

TIP: When you get your member ID card, use your ID number to create your My Health Toolkit account. Then you'll see cost information about copays and other details specific to your health plan.

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."

Using an HDHP plan: an example

Advantages

- Your HSA can help you save on taxes
- Once you reach your deductible, you out of pocket cost will be $0

Out-of-pocket costs

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

Ideal if…

…you don't 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's a good idea to keep your receipts in case your taxes are audited.

Taylor almost never goes to the doctor, but when she experienced a fever, chills, and chest congestion, she decided to visit urgent care. Taylor found a nearby in-network facility for treatment. Because Taylor hadn't yet met the plan's annual deductible, the health plan didn't cover the visit. Taylor had savings set aside to assist in paying for his qualified medical expenses, so this unusual visit wasn't a big deal. Taylor paid a $150 fee, which counts toward the plan's $5,000 annual deductible

To find a provider in your HDHP's network:

BCBS of AZ – National Network

- Visit your health plan's My Health Toolkit site. www.myhealthtoolkitaz.com
- At your health plan's My Health Toolkit member account,
- Select providers and services, then **Find Care.**

TIP: When you get your member ID card, use your ID number to create your My Health Toolkit account. Then you'll see cost information about copays and other details specific to your health plan.

Benefits Information on the Go

My Health Toolkit Mobile App

The My Health Toolkit Mobile app provides you with greater access to your insurance information. Use the app to:

- View your personalized insurance dashboard.
- Display your BCBSAZ ID Card.
- Locate physicians, hospitals, or other healthcare professionals nationwide.
- Learn about benefit discount programs, like dental, vision and pharmacy.

Get easy access to your benefits information by downloading the My Health Toolkit® mobile app today! It's free on the App Store or Google Play. Register quickly through the app using your birth date plus your member ID number or Social Security number. Or just log in if you're already a My Health Toolkit user

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.

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?

North Country HealthCare Pharmacy can offer you lower cost on your medications. Prescription must be from a North Country HealthCare provider to be filled by North Country Health Care Pharmacies.

For a current version of the prescription drug list(s), go to www.DisclosedRx.com or call 1-888-589-3340.

Use the mail
You can save time and money by getting your medications shipped directly to you through a mail-order service. You can have a larger quantity, usually a 90-day supply, regularly shipped to your door.

Shop around
Some pharmacies offer less expensive medications. Try calling pharmacies inside warehouse clubs or discount stores to see if they offer a lower price. Shopping around could pay off.

Try over the counter
For colds, headaches, and other common conditions, over-the-counter medications can sometimes work just as well as prescription ones—and cost a lot less, too.

Want to learn more? If you're considering this type of coverage, you must enroll when you first become eligible. To learn more and view detailed plan information, download the "iNGAGED Benefits" app from the App Store or Google Play or go to https://ingagedbenefits.com/login and use company code NCHC to log in.

How much will specific services cost?"

Benefit Feature (In Network)	HDHP $5,000		PPO $5,000	
Network	BCBS of AZ		BCBS of AZ	
Deductible (Single / Family)	$5,000 / $7,000		$5,000 / $10,000	
Coinsurance	0%		20%	
OOP Maximum (Single / Family)	$5,000 / $10,000		$6,600 / $13,200	
Office Visit Copays (PCP / Specialist)	0% after deductible		$10 / $25 - NCHC $25 / $75 - BCBSAZ	
Emergency Room	$150 copay, then 0% after ded Copay waived if admitted		$250	
Urgent Care	0% after deductible		$75	
In-patient Hospital	0% after deductible		20% after deductible	
Advanced Imaging - MRI, CT, PET	0% after deductible		20% after deductible	
Retail Rx	0% after deductible		$5 / $10 / $35 / $60 - NCHC $15 / $55 / $85 / $150 - BCBSAZ	
	Employee Per Pay Period Cost (26 pays)		Employee Per Pay Period Cost (26 pays)	
	Full time	Part Time	Full Time	Part time
Employee	$55.38	$303.46	$5.54	$166.30
Employee + Spouse	$223.85	$724.27	$123.23	$459.83
Employee + Child(ren)	$202.15	$722.65	$89.08	$404.44
Family	$444.00	$1228.85	$218.31	$679.99

Out-of-Network benefits are not shown. Services are covered at 50% vs 100% except preventative services Full benefit plan designs are provided via the company's iSolved site.

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

Want to learn more? - If you're considering this type of coverage, you must enroll when you first become eligible. To learn more and view detailed plan information, download the "iNGAGED Benefits" app from the App Store or Google Play or go to https://ingagedbenefits.com/login and use company code NCHC to log in.

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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, Teadoc will send it to a local pharmacy. You can also get your medication through the mail.

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

This program is available for members who participate and enroll in the National Alliance, BCBSAZ Medical Plan.

General Health

- Colds or flu
- Allergies
- Strains and sprains
- Digestive issues
- Sinus problems
- Pediatric care

Specialty Care

- Dermatology (skin conditions)
- Behavioral health therapy

Cost:

PPO Member cost share

- Medical $10 copay
- Counseling $25 copay
- Psychiatry $25 copay

HDHP Member cost share subject to deductible

- General Medical $57 charge subject to deductible
- Psychiatrist First Visit $230 subject to deductible
- Psychiatrist Ongoing visit $104 subject to deductible
- Licensed Therapist $94 subject to deductible
- Dermatology Visit: $89 subject to deductible

Start your eVisit today!

Register for Teladoc now – don't wait till you are sick!

1. Log in to your My health toolkit account at www.myhealthtoolkitaz.com
2. Select Providers & Services, and then Telehealth
3. Select launch a visit.

Workplace Wellness

Why Wellness?

Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual health care costs. We care about your total well-being and encourage Full time & Part time employees and their spouses to engage in our Wellness Program at no cost.

North Country HealthCare Wellness Program

Whether you're looking to eat better, become more active or focus on habits to help you get the recommended amount of sleep, Vitality will help you create your Personal Pathway™ to better health. Interact with the program at PowerofVitality.com and through the Vitality Today™ mobile app to plan healthy activities that inspire and help you earn Vitality Points™ to get the rewards you deserve. If you have a program-related question, please refer to the Guide to Vitality or contact a Vitality Specialist at 877.224.7117.

How to get started?

Start by registering

The first step is to create your own confidential Vitality member account by **registering at PowerofVitality.com**. It's quick and easy. Simply complete all of the required fields and accept the terms and conditions. When you're done, download the **Vitality Today mobile app** from the App Store or Google Play. Employees will need to use their 5-digit employee ID number as the "Principal Member's Employee ID Number" You'll use your PowerofVitality username and password to log in to the app.

With Vitality you can...

- Keep informed and inspired on current health trends and recommendations
- Link a compatible fitness device or app, including Fitbit, Garmin, Polar, Apple Watch, Samsung Watch, Apple Health, Samsung Health, Google Fit.
- Exchange reward points for gift cards in the mall for companies such as Adidas, Athleta, Calloway Golf, Champs Sports, Lululemon, Royal Caribbean, Vitamin Shoppe, Columbia, Oura Ring, Instacart, Petco, Macy's, Global Hotel Cards Powered by Expedia and Sunglass Hut
- Health Profile - Get the big picture of your health through the **Vitality Health Review**™ allows Vitality to get to know YOU a little better.
    - Each year, members will need to complete the Vitality Health Review (**VHR**) and Vitality Check
    - Completing the VHR within the first 90 days of the new plan year will earn members an extra 250 Points!
- Know your numbers complete a **Vitality Check.**
- Set goals that motivate you
- Points - Plan activities that inspire you - The **Points Planner** on the Vitality website categorizes the many activities for which you can earn Vitality Points to reach your desired Vitality Status®.
- Rewards - Enjoy your Rewards - With Vitality, your healthy victories – big and small - are rewarded with **Vitality Bucks**®
- Resources - Learn more about healthy choices - the **Guide to Vitality** is a comprehensive resource of program information.
- Vitality Mobile App - Stay connected

Get Rewarded by North Country Healthcare

At renewal, members will retain all unused Vitality Bucks, but will rollover 10% of Vitality Points

- Employees reaching Silver status will receive a $50 Vitality Mall Gift Card.
- Employees reaching Gold status will receive a $100 Vitality Mall Gift Card.
- Employees reaching Platinum status will receive a $200 Vitality Mall Gift Card.

To redeem, add a gift card from the mall to your cart and use an earned Vitality Mall Gift Card code to check out!

Spending Accounts

Health Savings Account (HSA)

What is it?

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

What are the benefits?

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

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

How do I qualify for an HSA?

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

- You are covered under a qualified medical plan.
- You are not enrolled in non-qualified health insurance outside of North Country HealthCare's HDHP plan.
- You are not enrolled in Medicare.
- You are not claimed as a dependent on someone else's tax return (excluding a spouse).
- You are not enrolled in a general Health Care Flexible Spending Account (Health FSA) or general Health Reimbursement Arrangement (HRA).

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

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

How do I get started?

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

- Step 1. Enroll in the North Country HealthCare High Deductible Health Plans.
- Step 2. Sign up for a Health Savings Account in iSolved, during open enrollment or new hire enrollment.

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

If you currently have a Health Savings Account on your own or with a previous employer, and wish to move it over to NCHC, please notify your Human Resources Business Partner, as additional steps will need to be taken to move/attach your account to North Country HealthCare.

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

A few rules you need to know:

- For 2025, the maximum contribution limit for employee and employer contributions in an employee's HSA account is $4,300 if you are enrolled in the HDHP for employee-only coverage, and $8,550 for employees with dependent coverage.
- It's important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax.
- There is a 20% penalty for using HSA funds on non-qualified health care expenses if you are under age 65. For more details about what are considered qualified health care expenses, visit www.healthequity.com.
- You may not be able to contribute to your HSA if you are entitled to Medicare. However, funds accumulated before Medicare entitlement may be used to reimburse your qualified medical expenses.
- You may not contribute to your HSA if you are covered under any medical benefits plan which is not an HSA-qualified high deductible medical plan (e.g., a spouse's non-HDHP medical plan, a general-purpose Health Care FSA, or Medicare). However, you may be covered by a Limited Purpose Health Care FSA, or an FSA which can be used after your HDHP deductible is met.
- Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon a **pro-rata** portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would normally be able to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first joins the HSA plan on September 1. However, under the full contribution rule, an employee is allowed to contribute the maximum annual amount, regardless of the number of months he/she was eligible to contribute to an HSA in the first year, if he/she is eligible to contribute to an HSA on December 1 of the first year and continues to be eligible to contribute to an HSA until December 31 of the following year (i.e., for the entire subsequent year).

TIP

How do I manage my HSA?

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

WHAT TO KNOW ABOUT YOUR HEALTH SAVINGS ACCOUNT

You own your HSA

Your money rolls over year after year

You choose how much to contribute (max. amounts apply)

Paired with a high-deductible health plan

You receive a triple tax advantage

Flexible Spending Accounts (FSA)

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

FSA Type	Detail
Health Care FSA	• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance. • Maximum contribution for 2025 is $3,300
Limited Purpose FSA	• Option for employees enrolled in a Health Savings Account (HSA) eligible plan. • Use this FSA to reimburse for eligible preventive care, dental and vision expenses. • Maximum contribution for 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. • Maximum contribution for 2025 is $5,000

What are the benefits?

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

How do I use it?

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

A few rules you need to know:

- Although the FSA plan year runs from January through December, the plan allows a run out period, 90 days after the end of the plan year, allowing you to be reimbursed for health care expenses incurred through December 31, 2025.

Supplemental Health Plans

Be prepared for the unexpected.

Critical Illness Coverage

If you choose to sigh up for this coverage, Mutual of Omaha 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.

What can critical illness coverage pay for?

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

What are examples of covered illnesses or conditions?

- Cancer
- Heart Attack
- Stroke
- Alzheimers's
- Kidney Failure
- Organ Transplant

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:

Benefit options

Election	Benefit Amounts & Guaranteed Issue
Employee	$5,000 minimum up to $50,000 (Guaranteed Issue $40,000)
Spouse	100% of Employee benefit election up to $40,000 (Guaranteed Issue $40,000)
Child(ren)	25% of Employee benefit election up to $10,000 (Guaranteed Issue $5,000)

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For additional information or to obtain a full schedule of benefits contact Human Resources.

Hospital Protection

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 Mutual of Omaha. This benefit will pay cash to you or your family to offset medical and non-medical bills that you get after staying in the in the hospital.

How can hospital insurance help?

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

- Copayments
- Deductibles
- Transportation expenses
- Childcare
- Lodging expenses for a companion
- Lost income

Benefits	Amounts
Hospital Admission	$1,100 per admission
Daily Hospital Confinement	$100 per day
ICU Admission	$2,200 per admission
Daily ICU Confinement	$200 per day

Here's an example of how Hospital Insurance works

Meet Trevor. Trevor had some complications from gallbladder removal surgery, which resulted in a 5-day hospital stay. Through his primary medical insurance, With the help of his Hospital Insurance coverage, which paid a $1,100 admission benefit.

100% Employee-Paid

If you elect the voluntary hospital insurance plan, 100% of the cost is deducted through payroll deductions. Rates are calculated by age and enrollment tier elected.

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible. 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 NCHC to login to the app or login online at https://ingagedbenefits.com/login.

Accident Insurance Plan

We all know they happen, but not everyone is prepared. Accident insurance is optional coverage through Mutual of Omaha that helps 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.

How can accident insurance help?

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

What are some common covered benefits?

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

Covered Event/Injury	Benefit Amount
Ambulance (ground)	Up to $1,500
Emergency room care	$300
Physician Office Visit	$100
Burns	Up to $20,000
Surgical	Up to $3,500
Medical Device	$300

100% Employee-Paid

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

Monthly post-tax rates are outlined below:

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible. 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 NCHC to login to the app or login online at https://ingagedbenefits.com/login.

Dental Plans

Dental Plan

Your Dental PPO Plan

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

Choose an in-network dentist

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

Using the Plan

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

Plan Highlights	Low Plan Delta Dental PPO Network		High Plan Delta Dental PPO Network	
Calendar Year Deductible				
Individual Per Person	$50		$50	
Plan pays up to Annual Maximum	$1,000		$1,500	
Preventive (deductible waived)	0%		0%	
Basic Services*	0% after ded		0% after ded	
Major Services*	40% after ded		40% after ded	
Orthodontia (deductible waived)	Excluded		50%	
Adult and Children (no age limit)	Excluded		Covered	
Lifetime Orthodontia Maximum	Excluded		$1,500	
Coverage Tier	**Low Plan Employee Cost Per Pay Period Deduction (26 Pays)**		**High Plan Employee Cost Per Pay Period Deduction (26 Pays)**	
	Full Time	**Part Time**	**Full Time**	**Part Time**
Employee	$13.77	13.77	$17.65	$17.65
Employee + Spouse	$27.26	$27.26	$35.32	$35.32
Employee + Child (ren)	$29.06	$29.06	$39.89	$39.89
Employee + Family	$44.69	$44.69	$60.69	$60.69

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

*Deductible applies to these services.

Want to learn more? If you're considering this type of coverage, you must enroll when you first become eligible. 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 **NCHC** to login to the app or login online at https://ingagedbenefits.com/login

Vision Plans

Vision Plan

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

Plan Highlights	In-Network	Out-of-Network
Wellvision Exam – Every 12 months	$10 copay	Up to $45
Materials Copay	$25 copay	N/A
Lenses – Every 12 months		
Single	$25 copay	Up to $30
Bifocal	$25 copay	Up to 50
Trifocal	$25 copay	Up to 65
Frames – Every 12 months		
Frames	$150 Allowance + 20% off balance after $25 copay	Up to $70
Featured Frame Brand Allowance	$170 Allowance	N/A
Walmart / Sam's Club Frame Allowance	$150 Allowance	N/A
Costco Frame Allowance	$80 Allowance	N/A
Contacts – Every 12 months, in lieu of lenses & frames		
Medically Necessary	100%	Up to $210 7
Elective	$150 Allowance, copay waived	Up to $105
Contact Lens exam (fitting and evaluation	Up to $60	N/A
Coverage Level	Employee Cost Per Pay Period Deduction (26 Pays)	
	Full Time	Part Time
Employee	$2.02	$3.87
Employee + 1 Dependents	$3.76	$5.61
Employee + 2 or more Dependents	$8.21	$10.05

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

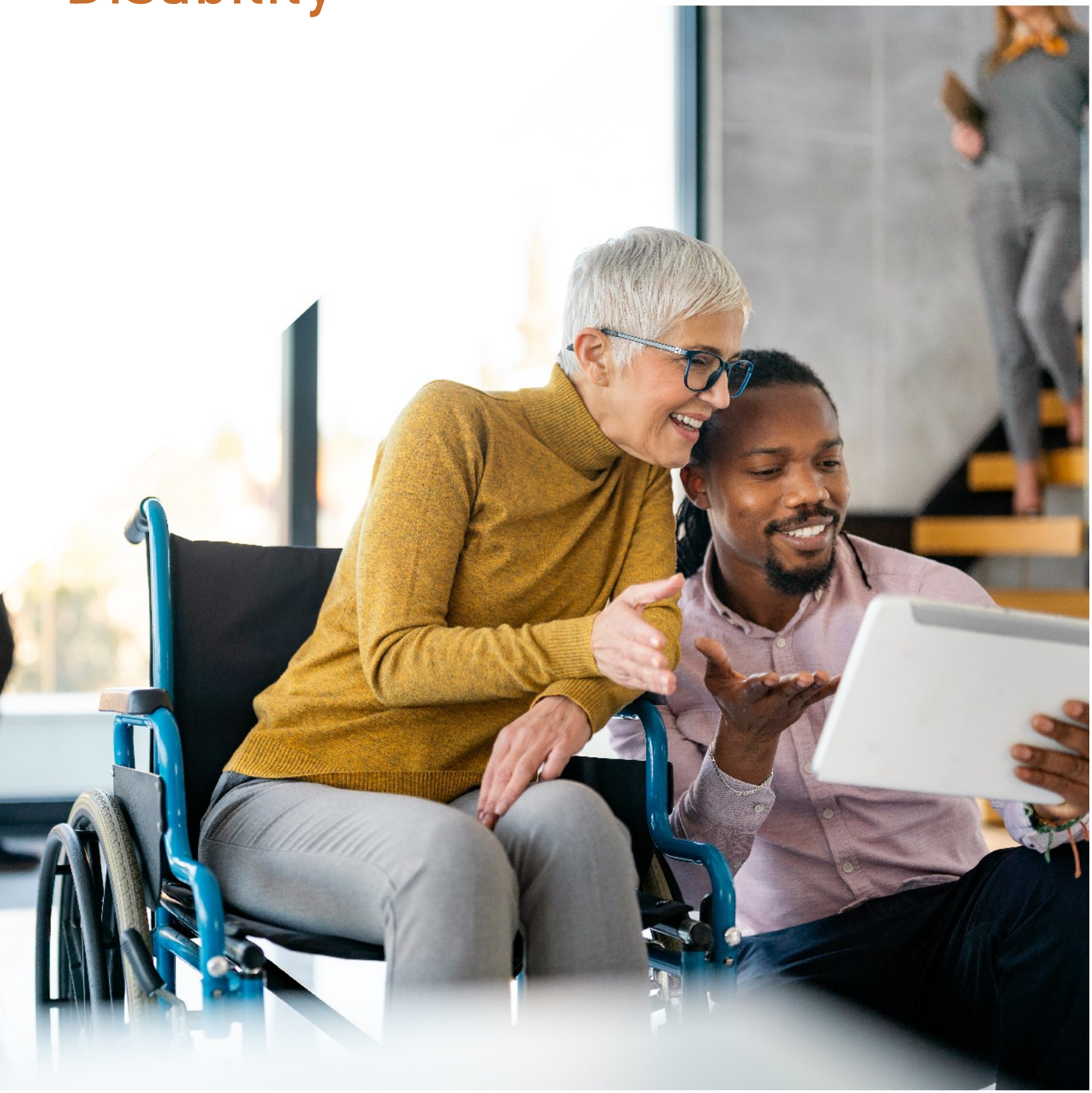
Five tips for having an excellent view

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

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

Want to learn more? - If you're considering this type of coverage, you must enroll when you first become eligible. 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 NCHC to login to the app or login online at https://ingagedbenefits.com/login.

Life & Disability



Life & Disability

Basic Life and AD&D

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

Paid for in full by North Country HealthCare, the benefits outlined below are provided by New York Life:

- Basic Life Insurance coverage in the amount of $50,000.
- AD&D coverage in the amount of $50,000.
- Please note, benefits may reduce when you reach age 65.

Voluntary Life and AD&D

If you would like to supplement your employer paid insurance, additional Life and AD&D coverage for you and/or your dependents is available for purchase on a payroll deduction basis through New York Life.

- For employees**:** Increments of $10,000 up to a $300,000 maximum with a guaranteed issue benefit of $100,000, if you enroll in the plan within 30 days of your initial eligibility. Elections above $100,000 will require completion of an Evidence of Insurability Form (EOI).
- For your spouse**:** Increments of $5,000 up to a $300,000 maximum or 100% of employee election, with a guaranteed issue benefit of $30,000, if you enroll in the plan within 30 days of your initial eligibility. Elections above $30,000 will require completion of an Evidence of Insurability Form (EOI).
- For your child(ren):
    - For eligible children under 14 days of age, employees who elect child coverage receive $1,000 of coverage.
    - For eligible children 14 days of age or older, employees may elect coverage in the amount of $10,000. (No medical questionnaire).

- Voluntary AD&D**:** Coverage is available for purchase in the same amounts, as voluntary life insurance amounts above.

During 2025 Open Enrollment, you may enroll in any amount up to the guaranteed issue without medical review. Any amounts of insurance over the guaranteed issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 70. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill.

Want to learn more? -

If you're considering this type of coverage, you must enroll when you first become eligible. 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 NCHC to login to the app or login online at https://ingagedbenefits.com/login.

Cost of Employee Voluntary Coverage

Age of Insured	Monthly Rate per $1,000
Less than 25	$0.040
25–29	$0.040
30–34	$0.051
35–39	$0.079
40–44	$0.115
45–49	$0.179
50–54	$0.293
55–59	$0.481
60–64	$0.752
65–69	$1.400
70 & over	$2.736
AD&D	**$0.025**

Cost of Spousal Voluntary Coverage

Age of Insured	Monthly Rate per $1,000
Less than 25	$0.040
25–29	$0.040
30–34	$0.051
35–39	$0.079
40–44	$0.115
45–49	$0.179
50–54	$0.293
55–59	$0.481
60–64	$0.752
65–69	$1.400
70–74	$2.736
AD&D	**$0.025**

Dependent Child Coverage

Benefit Amount	Monthly Premium
$10,000	$2.00 Per family

TIP

Required! Are Your Beneficiaries Up to Date?

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

- You can change your beneficiary designation at any time.
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.
- To select or change your beneficiary, update in iSolved.
- All benefit eligible employees must submit their beneficiaries with their 2025 Benefit Enrollment.

Short & Long Term Disability

Added protection

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

Your Plans	Coverage Details
Short Term Disability (STD) 100% Employer Paid	• Administered by New York Life, STD coverage provides a benefit equal to 60% of your weekly earnings, up to $1,000 per week, for a period up to 13 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) 100% Employer Paid	• If your disability extends beyond 90 days, the LTD coverage through New York Life can replace 60% of your monthly earnings, up to maximum of $5,000 or $10,000 per month (based on employee "class". Contact your Human Resource Business Partner for details.) • Your benefits may continue to be paid until you reach age 65 or 5 years, as long as you meet the definition of disability.

Tax considerations

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

Please note**:** Consult your tax advisor for additional taxation information or advice.

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible. 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 NCHC to login to the app or login online at https://ingagedbenefits.com/login.

Employee Assistance Program Program (EAP)

Employee Assistance Program (EAP)

North Country HealthCare understands that you and your family members might experience a variety of personal or work-related challenges. Through the EAP, you have access to resources, information, and counseling that are fully confidential and **no cost to you 24/7/365.**

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

Topics May Include	• Mental Health Support:
	• Marital, relationship or family problems.
	• Bereavement or grief counseling.
	• Substance abuse and recovery.
	• Workplace Stress.
	• Resiliency.
	• Work-Life Web Services
	• Lifestyle coaching
	• Community Support:
	• Childcare and eldercare.
	• Legal services and Identity theft resolution
	• Financial wellness
	• Educational materials.
	• Self-care programs
	• Integrated Digital Resources
	  ○ Sanvello App – On demand Self Help clinical techniques to help with stress, anxiety and depression – Anytime!
	  ○ Talkspace App – Support anytime you need – no appointments necessary
	  Text, video chat with a licensed, EAP provider
	  ○ Calm App

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

TIP

- Get in touch: 866-248-4096
  - Members should identify themselves as employees or dependents of North Country HealthCare. No company code is required.
- For online access, visit: www.liveandworkwell.com and use the company code: NCHC

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible. 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 **NCHC** to login to the app or login online at https://ingagedbenefits.com/login.

Retirement

Retirement

Your 401(k) & Roth Plan Options

Administered by Ameritas, the 401(k) plan allows you to plan for your future by investing a portion of each paycheck. Once you become eligible, you may elect to have a percentage of your paycheck withheld and invested in your 401(k) account, subject to federal law and plan guidelines.

Everyone dreams of a carefree retirement, but you'll need to plan – and save now – to have the retirement you want. Social Security alone may not meet all your future financial needs. You may have to dig into personal savings. Fortunately, your 401(k)-retirement savings plan helps you save for retirement easily and offers many tax advantages. Here are guidelines and helpful information for you to start contributing to your financial future:

Enrollment & Account Access

- Enroll in the 401(k) plan through iSolved enrollment system.
- Check your 401(k) account balance, view your contributions, change your investments and more by visiting www.ameritas.com.
- For login or password assistance, please contact Ameritas Customer Service: 800-845-9995 or visit www.ameritas.com

Contribution Limits: For 2025, the IRS annual contribution limits are $23,000 for everyone under age 50 or $30,000 for anyone that is age 50 or over prior to December 31, 2025. 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.

- All employees are eligible to participate in the plan on the date of hire and are 18 years of age or older.
- If you do not make an election for your initial 401k enrollment, you will be automatically enrolled at 1%, pre-tax contribution rate unless you elect a different percentage through the iSolved system.
- Participants can make Pre-Tax or Roth contributions to the Plan through payroll deductions up to the maximum allowed by the IRS for the calendar year.
- Participants can modify their contribution percentage throughout the year through iSolved.
- After 1 year of eligible service, North Country Healthcare will match contributions dollar for dollar up to 4% of compensation per pay period. Don't miss out on this benefit!
- Participants have a well-diversified investment lineup to create a personalized portfolio to meet individual needs. If investments are not selected, you will be defaulted into a T.Rowe Price Target Date fund based on when you will be 65 years of age.
- You can change your investment selections through your Ameritas website.
- Employees will have 24/7 online access to your account at www.ameritas.com.
- Rollovers are accepted into your Plan. Contact Benefit & Financial Strategies – they can help you.
- Under certain circumstances, you may be able to borrow money from your account through the Loan Option located online.

Benefit & Financial Strategies is full-service, and has local representatives available in downtown Flagstaff. Employees can contact Brani Boudreaux for plan questions or Bill Morrison for investment advice and retirement planning.

BENEFIT & FINANCIAL STRATEGIES, LLC.

510 N. Humphreys St. Flagstaff, AZ 86001
www.benefitandfinancial.com
928-774-0695

Perks & More

Perks & More

My Secure Advantage

At New York Life Group Benefits Solutions (NYL GBS), we know that financial issues are one of the leading causes of stress in America. That is why we offer a full-service financial wellness program. My Secure Advantage (MSA) can help support the financial health of your household, at no additional cost to you.

Visit www.nylgbs.mysecureadvantage.com for more information or to register and access online tools and educational resources and create legal documents or call 888-724-2262 to speak with an My Secure Advantage representative.

Employee Assistant Program through New York Life Group Benefit Solutions

You have three face-to-face sessions with behavioral counselors available to you and your household members in addition to your mental health support through Optum EAP. Achieve work/life balance for help handling life's challenges, go online for articles and resources and family, care giving, pet care, aging, grief, balancing priorities, working smarter and more. Visit www.nylgbs-lap.com or call 800-538-3543 for 24/7 support.

New York Life Group Benefits Solutions - Secure Travel

Additional protection when you travel. Emergencies can happen while traveling, help is only a phone call away with New York Life Group Benefit Solutions Secure Travel.

From the United States and Canada, call 888-226-4567; from other locations call collect 202-331-7635.

- Email: ops@us.generaliglobalassistance.com
- Policyholder Name: North Country HealthCare
- Policy# OK971379

Discounts and Special Offers

You can always benefit from saving money! In an effort to support the financial sustainability of our employees, we partner with various businesses to provide staff discounts. From banking and accounting services to travel and entertainment, there is surely a little something for everyone. A complete list of great discounts and special offers and provided on ASPEN under Human Resources/Employee Perks

Here are some examples:

- Car Rentals
- Entertainment
- Child Care
- Pet Insurance
- Banks & Credit Unions
- Cell Phone Service
- Gym Memberships
- Legal document Services

LegalShield & IDShield

Legal Shield gives you the power to talk to an attorney about any personal or legal issue. Whether it's big, small or in between, the LegalShield Provider Law Firm will be there to offer advice or assistance on a variety of issues such as: child support, divorce, bankruptcy, death of a family member, tax disputes, lawsuits, traffic tickets, vendor disputes, etc. They can assist with document preparations such as wills, living wills and health care provider of attorney.

Identity theft affects millions of Americans each year. It causes financial damage and emotional harm that can take years to recover. IDShield identity theft protection will equip you with the information and expertise you need to help protect yourself and your family against identity theft and resolve related issues.

You can enroll in this benefit directly through ASPEN under Human Resources/Employee Perks.

Employee Education Assistance Program

- *Continuing Education for Providers*: All full and part time providers receive up to $2,000 per year for continuing medical education activities, pro-rated based upon employment status and budget resources available. Dual-boarded Physicians are allowed an extra $1,000 in expense reimbursement in recognition of higher continuing medical education requirements. In addition to continuing medical education activity, all eligible providers will be reimbursed for job related professional subscriptions, journals and membership dues. Reimbursement for these expenses will follow established CME guidelines.

- *Advanced Education Reimbursement Program*: All eligible employees working at least 30 hours per week and having completed one year of service may apply for tuition reimbursement for advance education goals. This benefit offers a maximum reimbursement of up to $5,250 per calendar year. Cannot be combined with participation in the Student Loan Repayment Program.

- *Student Loan Repayment Program*: All eligible employees working at least 30 hours per week and having completed one year of service may apply for student loan repayment assistance towards private and federal student loans in the employee's name for employee's education. This benefit offers a maximum of up to $5,250 per calendar year. ParentPLUS loans are not eligible. Cannot be combined with participation in the Advanced Education Reimbursement Program

Costs, Directory, and Required Notices

Cost Breakdown

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

Coverage Level	Payroll Deduction Employee Premiums Per Pay Period Full Time	Payroll Deduction Employee Premiums Per Pay Period Part Time
National Alliance PPO $5,000 (26 pays)		
Employee Only	$5.54	$166.30
Employee and Spouse/Domestic Partner	$123.23	$459.83
Employee and Child(ren)	$89.08	$404.44
Employee and Family	$218.31	$679.99
National Alliance HDHP $5,000 (26 pays)		
Employee Only	$55.38	$303.46
Employee and Spouse/Domestic Partner	$223.85	$724.27
Employee and Child(ren)	$202.15	$722.65
Employee and Family	$444.00	$1,228.85
Delta Dental Low Plan (26 pays)		
Employee Only	$13.77	$13.77
Employee and Spouse/Domestic Partner	$27.26	$27.26
Employee and Child(ren)	$29.06	$29.06
Employee and Family	$44.69	$44.69
Delta Dental High Plan (26 pays)		
Employee Only	$17.65	$17.65
Employee and Spouse/Domestic Partner	$35.32	$35.32
Employee and Child(ren)	$39.89	$39.89
Employee and Family	$60.69	$60.69
VSP Vision (26 pays)		
Employee Only	$2.02	$3.87
Employee + 1 Dependent	$3.76	$5.61
Employee + 2 or more Dependents	$8.21	$10.05

Directory & Resources

Below, please find important contact information and resources for North Country HealthCare.

Information Regarding	Contact Information	
Enrollment & Eligibility		
Human Resource Business Partners: • Vicki Sutliff, Human Resource Business Partner Eastern & Western Corridor • Erika Anderson, Human Resource Business Partner Central & Western Corridor	928-607-3046 928-522-1081	vsutliff@nchcaz.org eanderson@nchcaz.org
Medical Coverage		
National Alliance Blue Cross Blue Shield of AZ Network: BCBS of AZ • National Alliance Customer Service • National Alliance Prior-Authorization • National Alliance Nurse Line	877-317-4935 855-838-5897 877-836-0701	www.myhealthtoolkitaz.com
Pharmacy Coverage		
DisclosedRX	888-589-3340	www.disclosedrx.com Mail order: https://presmartinc.com/online_forms.htm
Wellness		
Vitality Health	877-224-7117	www.PowerofVitality.com
Dental Coverage		
Delta Dental of Arizona • Low & High DDAZ PPO	800-352-6132	www.deltadentalaz.com/member
Vision Coverage		
VSP • VSP Choice Network	800-877-7195	www.vsp.com
Life, AD&D and Disability		
New York Life • Basic Life / AD&D • Voluntary Life / AD&D • Short-Term Disability • Long Term Disability	800-362-4462	Filing a Life, AD&D, or Disability claim: www.newyorklife.com/group-benefit-solutions/forms Work Wellness Website: www.newyorklife.com/group-benefit-solutions/employees/work-wellness
Secure Travel		
New York Life Group Benefit Solutions	888-226-4567 US or Canada 202-331-7635 / Group #57	ops@us.generaliglobalassistance.com
My Secure Advantage		
New York Life Group Benefit Solutions	888-724-2262	www.nylgbs.mysecureadvantage.com
NY Life Assistance Program		
New York Life Group Benefit Solutions	800-538-3543	www.nylgbs-lap.com
Voluntary Worksite		
Mutual of Omaha • **Accident Insurance** • **Critical Illness** • **Hospital Insurance**	800-775-6000 #G000CDEJ8	www.mututalofomaha.com /employer-based-plans/accident-insurance https://www.mutualofomaha.com/employer-based-plans/critical-illness-insurance https://www.mutualofomaha.com/employer-based-plans/hospital-indemnity-insurance
HSA & FSA Bank Accounts		
HealthEquity	866-346-5800	https://www.healthequity.com
401(k) Retirement Plan Adviser		
Ameritas – 401k	800-277-9739	www.ameritas.com Forms: rpforms@ameritas.com
Employee Assistance Plan		
Optum EAP	866-248-4096	www.liveandworkwell.com Company code: NCHC
Legal & Identity Theft Services		
Legal / ID Shield	800-654-7757	www.legalshield.com/info/nchcaz

Information Regarding	Contact Information	
Financial Services & Retirement Planning		
Benefit & Financial Strategies	928-774-0695	Email: info@benefitsandfinancial.com Web: www.benefitandfinancial.com
Benefits Broker / Benefit Questions		
Marsh & McLennan Insurance Agency LLC Client Executive- (Barb Elcess) Claims Advocate- (Shan O'Connor)	520-722-7104 602-385-7069	Barb.Elcess@MarshMMA.com Shan.O'Connor@MarshMMA.com

Guidelines/Evidence of Coverage

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

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

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

The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Medicare Part D
Creditable Coverage Notice

Important Notice from North Country HealthCare
About Your Prescription Drug Coverage and Medicare

2024 & 2025	**PPO $5,000**	**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 North Country HealthCare 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. **North Country HealthCare has determined that the prescription drug coverage offered by the North Country HealthCare 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 North Country HealthCare coverage as an active employee, please note that your North Country HealthCare 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 North Country HealthCare coverage as a former employee.

You may also choose to drop your North Country HealthCare coverage. If you do decide to join a Medicare drug plan and drop your current North Country HealthCare 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 North Country HealthCare 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 North Country HealthCare 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).

Name of Entity/Sender: North Country HealthCare
Contact--Position/Office: Human Resource Business Partner
Address: 2920 N. 4th St., Flagstaff, AZ 86004
Phone Number: 928-522-9860

Medicare Part D
Non-Creditable Coverage Notice

Important Notice from North Country Healthcare
About Your Prescription Drug Coverage and Medicare

2025	**HDHP $5,000**	**Non- Creditable**
2024	**HDHP $3,500**	**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 North Country Healthcare 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. **North Country Healthcare has determined that the prescription drug coverage offered by the North Country Healthcare 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 [Insert Name of Plan]. 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 North Country Healthcare. 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 **North Country Healthcare**, 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 North Country Healthcare, coverage as an active employee, please note that your **North Country Healthcare** 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 **North Country Healthcare** coverage as a former employee.

You may also choose to drop your **North Country Healthcare** coverage. If you do decide to join a Medicare drug plan and drop your current **North Country Healthcare** 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 **North Country Healthcare** 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 **North Country Healthcare** 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).

Name of Entity/Sender: North Country HealthCare
Contact--Position/Office: Human Resource Business Partner
Address: 2920 N. 4th St., Flagstaff, AZ 86004
Phone Number: 928-522-9860

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in North Country HealthCare 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 Human Resources, 928-522-9860 hr@nchcaz.org

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.

North Country HealthCare 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 North Country HealthCare, 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 North Country HealthCare, 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 North Country HealthCare HIPAA Privacy Officer or 928-522-9860 or hr@nchcaz.org

North Country HealthCare
Attention: HIPAA Privacy Officer

2920 N. 4th St.
Flagstaff, AZ 86004
928-522-9860

Effective Date

This Notice as revised is effective January 2025.

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 www.nchcaz.org. 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: masspremassistance@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 and CHIP**
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 928-522-9860 hr@nchcaz.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 at hr@nchcaz.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 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**.

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

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
North Country HealthCare
Attention: Human Resource Business Partner
2920 N. 4th St.
Flagstaff, AZ 86004
hr@nchcaz.org

HIPAA Notice of Availability of Notice of Privacy Practices

The North Country HealthCare (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact North Country HealthCare, Chief Information Officer, 2920 N. 4th St., Flagstaff, AZ 86004 928-522-9860.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

HIPAA Wellness Program Reasonable Alternative Standards Notice

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at Human Resource Benefit Partner at hr@nchcaz.org and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

EEOC Wellness Program Notice

Notice Regarding Wellness Program

North Country HealthCare Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA or to participate in the blood test or other medical examinations.
However, employees who choose to participate in the wellness program will receive an incentive of Vitality Points for specified challenges or activities. Although you are not required to complete the HRA, only employees who participate will receive incentives.

You may request a reasonable accommodation or an alternative standard by contacting Human Resource Business Partners at hr@nchcaz.org.

The information from your HRA will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as webinars, activities. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and North Country HealthCare may use aggregate information it collects to design a program based on identified health risks in the workplace, North Country HealthCare wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) Vitality Health Coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources Benefits Partners at hr@nchcaz.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:

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

- Generally, your health plan must:

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

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

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

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

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

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

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills.

Notice Regarding Availability of Health Insurance Exchange

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

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 North Country HealthCare		4. Employer Identification Number (EIN) 86-0663432
5. Employer address 2920 N. 4th Street		6. Employer phone number 928-522-1087
7. City Flagstaff	8. State AZ	9. ZIP Code 86004
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above) 928-522-1087		12. Email address hr@nchcaz.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:

  Part-time & Full-time regular employees working 30 hours or more per week

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

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

  ☐ We do not offer coverage.

- ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

Notes

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