



2023-2024 BENEFITS

MINGUS UNION HSD NO. 4



BEFORE WE BEGIN

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HOW TO USE THIS GUIDE

The Kairos plan runs from July 1 to June 30 of each year. This guide provides a summary of benefit options to help you make the right decisions for you and your family.

Keep a copy of this guide handy throughout the year. It can be useful when specific care scenarios come up.



TIP: When you see a QR code like this one, scan it with your cell phone to find more information.

ENROLLMENT CHECKLIST



CHOOSE YOUR PLAN

Select a medical program option and decide who you're going to cover.



MAKE A CONTRIBUTION TO YOURSELF

If you have the option to enroll in a high deductible health plan (HDHP), don't miss out on making health savings account (HSA) contributions.



TAKE CARE OF YOUR LOVED ONES

Review and update beneficiary designations for life insurance benefits as needed.



ARE YOUR DEPENDENTS STILL ELIGIBLE?

Confirm that any dependents up to age 26 are still eligible to be enrolled.



CHOOSE YOUR OTHER COVERAGES

If applicable, review and decide whether to elect any additional employee-paid benefits.

KAIROS

General plan questions, claims questions, and ID cards

888.331.0222

svc.kairoshealthaz.org

TELADOC

Telehealth

800.835.2362

teladoc.com

GOT QUESTIONS?

UMR

Medical benefits, eligibility, and ID cards

844.212.6811

umr.com

MAXORPLUS

Prescription benefits

800.687.0707

maxorplus.com

WHAT'S NEW?

LISTEN UP!

It's important to pay close attention to the changes in this section, which take effect at the start of the plan year (July 1).



NEW FOR 2023-2024

1. Teladoc coverage is available with no cost-share on all medical plans, including HDHPs, until new federal regulations tell us otherwise.
2. We continue to expand our one-of-a-kind clinical advocacy program! We now have a dedicated mental health nurse to assist you with your mental health and wellbeing needs.
3. We have a new lifestyle management program for employees, known as Real Appeal. This is an online weight loss program to help individuals make positive lifestyle changes. There is no cost for enrollment.
4. Fees for Active&Fit gym memberships will increase from \$25/month to \$28/month beginning April 1, 2023.
5. There are some great enhancements to supplemental life, short-term disability, and worksite products. If your plan offers these products through Kairos, you'll find discussions on the appropriate benefit pages.

PLAN RULES

WHO'S ELIGIBLE?

Eligibility varies by employer, but here are some general eligibility categories:

- ✓ Full-time employees
- ✓ Part-time employees (if allowed by your employer)
- ✓ Active board members or council members, as permitted by their organizations
- ✓ Dependents of enrolled employees, including:
 - lawfully married spouses
 - domestic partners (if allowed by your employer; domestic partner's children are not eligible)
 - dependent children up to age 26
 - unmarried children who are mentally or physically handicapped and fully dependent on the enrolled employee for support and maintenance

WHEN CAN I MAKE A CHANGE?

You can make changes or elect benefits once a year during open enrollment. Outside of open enrollment, the IRS says a "qualified life event" must occur in order to make changes.

If you experience a qualified life event and need to make a change to your benefits, you must notify your employer within **31 days** of the event. Otherwise, you will have to wait until the next open enrollment period.



DAYS

Below are examples of qualified life events that may make a mid-year change possible:

- | | |
|---|---|
| ✓ Marriage, divorce, legal separation, or annulment | ✓ Change in your spouse's employment or involuntary loss of health coverage under another employer's plan |
| ✓ Birth, adoption, placement for adoption, or legal guardianship of a child | ✓ Change in your dependent's eligibility status |
| ✓ Death of a dependent | |

Newborns are not automatically added to your medical coverage. You must notify your employer within 31 days of the date of birth and pay the full premium amount for the month the child is added.



If you lose medical coverage through the Marketplace mid-year, you may not then join the Kairos plan. You may, however, drop your Kairos medical coverage to join a Marketplace plan mid-year.

WHAT DOES IT ALL MEAN?

Let's talk through some health insurance terms and make this easy.

*Scan to watch
a cool video*



DEDUCTIBLE

This is the amount of money you have to pay each plan year (July to June) for covered services before your health insurance benefits kick in.

COINSURANCE

This is a percentage of covered medical costs you pay once you meet your deductible. The plan pays the rest.

OUT-OF-POCKET MAXIMUM (OOP)

This is the most you'll pay for covered services during the plan year. The out-of-pocket maximum puts a cap on health care costs if you ever have a major illness or injury.

EMBEDDED DEDUCTIBLE

Individual family members have their own deductibles AND there's a deductible for the family as a whole. After an individual meets his or her deductible, the plan begins to pay benefits for that person. Once the family deductible is met, the plan pays benefits for all.

NON-EMBEDDED DEDUCTIBLE

The entire family shares a single deductible. The family deductible must be met before the plan begins to pay benefits.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) VS. PPO PLAN

An HDHP is a type of medical plan that has a lower monthly premium but a higher annual deductible. It's usually paired with a health savings account (HSA) to help pay medical expenses.

A PPO is a plan that has a higher monthly premium but a lower annual deductible. PPO plans sometimes have copays for services, unlike HDHPs.

IN-NETWORK VS. OUT-OF-NETWORK

In-network providers are contracted to provide services at a discounted rate. Out-of-network providers are not. Staying in-network is usually the best way to save money on your health care.

INPATIENT VS. OUTPATIENT

Inpatient services are those received when you're admitted to a hospital or facility and spend at least one night. Outpatient services can vary, but they're services received in a facility that you're not admitted to.

PRIOR AUTHORIZATION

This is pre-approval that is required for certain services, prescriptions, and medical equipment to be covered by the plan. It's sometimes called "preauthorization" or "precertification."

How does my medical plan work?



MEDICAL BENEFITS

UMR/UNITEDHEALTHCARE

UMR is the medical claims processor and uses the UnitedHealthcare (UHC) Choice Plus network. This is a PPO network, which is a group of health care providers who discount what they charge you for services. By staying in-network, services will cost you less.



Where does Kairos fit in?



KAIROS The Plan

Kairos manages and funds all of the health care plans and voluntary coverages. We also work closely with your employer to administer your benefits.



UnitedHealthcare Medical Network

Kairos medical plans use the UnitedHealthcare network. If your doctor asks what network you have, you'll say, "United."



UMR Claims Handling

UMR processes your medical claims. When you see your doctor, he or she submits the claim to UMR. For questions about your medical coverage, call Kairos or UMR (not United).

MANAGE YOUR BENEFITS

Create your mobile-friendly account at umr.com to take full advantage of your medical benefits. You'll need to have your ID card handy in order to register.

Once you're in, you can:

- ✓ View/print/order ID cards
- ✓ View medical claims
- ✓ Monitor your deductible and out-of-pocket limits
- ✓ Shop for the best and most cost-effective care



Scan to learn about the new and improved UMR mobile app

FIND A DOCTOR

If you want to find a doctor, there's no need to log in! Instead, follow these simple steps:

- ✓ Go to umr.com
- ✓ Select "Find a Provider"
- ✓ In the Provider Network search bar, type the network name: **UnitedHealthcare Choice Plus**
- ✓ Click search, then view providers
- ✓ Type in your address or ZIP code

Now you'll be able to search by provider name, locations, services, and more.

PRESCRIPTION BENEFITS

MAXORPLUS



When you enroll in Kairos medical coverage, you automatically receive prescription drug coverage through MaxorPlus. This benefit allows you to fill prescriptions through any participating pharmacy listed in the MaxorPlus pharmacy network.

Sign up for the MaxorPlus member portal to:



Locate the closest and most cost-efficient network pharmacy



View the plan formulary (a list of prescription medications that may be covered under the plan)



Look up your prescription history and plan costs

TIPS FOR SAVING ON PRESCRIPTIONS

Depending on your medication type, dosage, and frequency, the dollars can add up quickly. But you have options for lowering your out-of-pocket costs. Try these simple steps to help you save a buck or two!

✓ TAKE THE GENERIC

Generics have the same strength and active ingredients as the name brand version of your medications. The only difference is, they're significantly cheaper. Talk to your prescriber to see if generics are right for you.

✓ SHOP AROUND

Just like you might hunt for those great Black Friday deals, you can do comparison shopping for medications. Log in to the MaxorPlus member portal and use the copay calculator to find the most cost-effective pharmacy near you. (Believe it or not, not all pharmacies charge the same amount for the same medication.)

✓ USE MAIL ORDER

Mail order delivers medications directly to your doorstep. If you're taking a generic, it will cost you less than it does to go to your local pharmacy. For example, if a prescription costs \$25 for a three-month supply at retail, it could cost \$20 through mail order. That's like getting three months free every year!

✓ SIGN UP FOR MYMAXORLINK

The myMaxorLink discount program does the work for you. Once enrolled, you'll automatically receive information on lower-cost prescriptions, reminders specific to your coverage, and other important health updates. Call 888.596.0723 to enroll or go to mymaxorlink.com/maxorplus.

CLINICAL ADVOCACY: EXPERTS ON *YOUR* SIDE

CLINICAL ADVOCACY PROGRAM

Navigating health care and insurance can be complicated and leave you feeling overwhelmed. That's where we come in. Through the Kairos Clinical Advocacy Program, our dedicated in-house nurses help guide you through the health care system, choose the best treatment, and keep your costs to a minimum.

With this program, you have:

- a champion in your corner who not only has a clinical background but understands your insurance coverage and genuinely wants to help
- a concierge to compare costs for you and help you get the best value

Examples of how our clinical advocacy nurses help:

- ✓ Acting as the liaison between you, your doctor, and your insurance
- ✓ Coordinating with your health care providers when you need an alternative site of care
- ✓ Saving you money with manufacturer's medication programs or community assistance programs
- ✓ Guiding you through the prior authorization (PA) process

Real Story from a Real Kairos Member

A Kairos participant (let's call her Sidney) was told by her doctor that she was going to need brain surgery. Sidney was understandably anxious, but her doctor said it would be six weeks before the surgery could be scheduled.

Sidney was lost and needed help, so she turned to the Kairos Clinical Advocacy Team, which did what they do: sprang into action.

The team went back and forth with Sidney's doctor, trying to get her surgery scheduled sooner. Nothing came of their efforts. With Sidney's permission, the team connected her to a different surgeon.

Sidney met with the new doctor who, naturally, took a second look at her condition. The doctor determined that Sidney didn't need brain surgery after all! Instead, he prescribed medication for her condition.

The Positive Outcome for Sidney

- Avoided a scary, life-altering surgery
- Returned to work in under 3 months
- Improved her quality of care
- Saved herself thousands of dollars in medical bills (*and saved the Kairos plan 100s of thousands of dollars*)

No matter what your situation may be, you have a team of health care experts on your side with Kairos.

Give us a call to learn more.









WELLBEING

WHAT'S "WELLNESS" ALL ABOUT?

Wellness is more than skipping out on a donut for breakfast one day or trying to remember to de-stress after a tough meeting. It's a measure of both your mental and physical health, involving nearly every aspect of your life. It's about promoting a healthier and happier whole person.

We offer different wellness programs and activities for you to choose from. Participation is optional unless stated otherwise.

-  **Active&Fit fitness program**
\$28/month for access to 11,000+ fitness centers. Plus, online workout videos and life coaching.
-  **Online health center**
Online activities to promote healthy eating, weight management, and more.
-  **Lifestyle management program**
Online weight loss program to help employees make positive lifestyle changes.
-  **Maternity care program**
For pregnant moms or those who are planning to be. Includes a \$25 reward for completion!
-  **Ongoing condition care program**
For those who need help when managing chronic conditions like diabetes, COPD, and asthma.
-  **Complex condition care program**
For assistance with complex cases such as transplants, oncology, and neonatal care.

PREVENTION IS PRICELESS

We want to help you stay healthy. That's why the Kairos plan covers preventive care services for free, with no age restrictions when you visit an in-network provider.

Examples of preventive benefits include:

- ✓ Prostate screenings
- ✓ Immunizations and flu shots
- ✓ Hearing exams
- ✓ Mammogram screenings
- ✓ Colonoscopy screenings
- ✓ Cancer screenings
- ✓ Generic contraceptives
- ✓ Blood pressure tests

Your doctor must use wellness codes when billing these services, or your service will not be covered at 100%. To make sure wellness codes are billed correctly, inform your provider when scheduling your appointment that you need a wellness visit.

You should also know that if at the time of your appointment, any issues other than your preventive screening are addressed, it's likely that the billing codes will be changed from wellness to diagnostic, and the fees will not be covered at 100%. If you're having issues with a wellness claim, contact the Kairos team.



TELEHEALTH

TELADOC

Teladoc allows those enrolled in the medical plan to use their phone or computer to conduct a live virtual visit with a board-certified medical professional—any day, anytime, anywhere.

Teladoc benefits include general medicine, mental health, and dermatology for non-emergency matters like those below:

General Medicine	Mental Health	Dermatology
<ul style="list-style-type: none"> ✓ Cold and flu symptoms ✓ Allergies and sinus infections ✓ Pink eye ✓ Sore throat ✓ Flu symptoms ✓ Medically-necessary prescriptions 	<ul style="list-style-type: none"> ✓ Stress and anxiety ✓ Depression ✓ Trauma ✓ Grief ✓ Burnout ✓ Medication management 	<ul style="list-style-type: none"> ✓ Eczema ✓ Psoriasis ✓ Poison Ivy ✓ Rashes ✓ Rosacea

New for 2023-2024: General medicine visits are available to all enrollees, including HDHPs, at no additional cost (until new federal regulations tell us otherwise).

IMMEDIATE CARE AT A LOWER COST

Skip long lines

Did you know that 60% of patients have to wait at least 2 weeks for an in-office visit with their PCP?

Avoid high costs

The average cost for different visit types is as follows:

- ER: \$2,800
- Urgent care: \$136
- **Teladoc: \$0**

Avoid the long lines, wait times, and expenses of the ER. Use your telehealth benefits 24/7 for non-emergency matters.



EAP

COMPSYCH EMPLOYEE ASSISTANCE PROGRAM (EAP)

Everyone can use a little help sometimes. That's where your EAP benefit comes in. Through ComPsych's EAP, you can speak with a highly-trained and compassionate guidance consultant who can help you and your family 24/7 with things like:

- ✓ Stress and anxiety
- ✓ Relationship/marital conflicts
- ✓ Grief, loss, and life adjustments
- ✓ Substance abuse
- ✓ Minor depression management

Your benefit includes 6 one-on-one counseling sessions per family member, per issue, per year at no cost to you.

WORK-LIFE SOLUTIONS

Get the everyday help you need with ComPsych's Work-Life Solutions. Call the number at the bottom of the page for assistance with topics including:

- ✓ Finding child or elder care
- ✓ Housing searches
- ✓ Seeking financial assistance
- ✓ Finding pet care
- ✓ Sending a child off to school
- ✓ Planning a major project or event

BONUS!

Online guidance resources



When you visit the ComPsych website, you'll find get more benefits with your benefits. You'll have 24/7 access to vital information, tools, and support.

What to Expect:

- Product and service discounts
- Educational articles, podcasts, and videos
- On-demand trainings
- "Ask the Expert" personal responses to your questions

How to Access:

1. Go to www.guidanceresources.com
2. Click Register
3. Enter Web ID: **KAIROSEAP**
4. Complete your registration

AND NOW... THE MEDICAL PLANS!



COPAY PLAN BENEFIT OVERVIEW		IN-NETWORK ³	OUT-OF-NETWORK ³
DEDUCTIBLE ¹	\$750/employee \$1,500/employee +1 \$2,250/employee +2 or more	\$1,500/employee \$3,000/employee +1 \$4,500/employee +2 or more	
OUT-OF-POCKET MAXIMUM ²	\$5,000/employee \$10,000/employee +1 or more	No maximum	
OFFICE VISITS	\$25 copay primary care physician \$50 copay specialist	Deductible, then 50%	
URGENT CARE	\$50 copay	Deductible, then 50%	
EMERGENCY ROOM	Deductible, then 20%	Deductible, then 20%	
WELLNESS SERVICES (ADULT/CHILD)	No deductible, \$0	Deductible, then 50%	
TELEHEALTH (TELADOC)	No deductible, \$0	Not available	
AMBULATORY SURGICAL CENTER	\$250 copay	Deductible, then 50%	
NON-HOSPITAL INFUSION CENTER	\$250 copay		
NON-HOSPITAL RADIOLOGY CENTER	\$75 copay		
NON-HOSPITAL LAB/PATHOLOGY	\$25 copay		
HOSPITAL RADIOLOGY			
HOSPITAL LAB/PATHOLOGY			
AMBULANCE			
INPATIENT/OUTPATIENT HOSPITAL			
OUTPATIENT LAB AND X-RAY (INCLUDING MRI, PET, AND CT)			
OUTPATIENT BEHAVIORAL VISIT			
PRESCRIPTIONS			
RETAIL (30-day supply)	<ul style="list-style-type: none">• Generic: \$10• Preferred: \$60• Non-preferred: \$110• Specialty: 50% (maximum of \$150)		
MAIL ORDER (90-day supply)	<ul style="list-style-type: none">• Generic: \$20• Preferred: \$120• Non-preferred: \$220		

¹This plan has an embedded individual deductible and out-of-pocket maximum. This means that although a deductible and out-of-pocket maximum apply to the family as a whole, no individual will be responsible for more than his/her individual deductible before the plan pays benefits for that person, and no individual will be responsible for more than his/her individual out-of-pocket maximum. All benefits are subject to the deductible, unless otherwise noted. The medical plan deductible does not apply to retail and mail order prescription drug copays.

²The out-of-pocket maximum includes deductibles, copayments, and coinsurance for all medical and prescription plan benefits.

³The in-network and out-of-network deductibles and out-of-pocket maximums are separate. This means that amounts applied toward the in-network deductible and out-of-pocket maximum do not also apply toward the out-of-network deductible and out-of-pocket maximum. Similarly, amounts applied toward the out-of-network deductible and out-of-pocket maximum do not also apply toward the in-network deductible and out-of-pocket maximum.

Please note: Information provided above may be subject to change at any time.

\$1,500 HDHP (\$3,000 FAMILY) BENEFIT OVERVIEW

	IN-NETWORK ⁴	OUT-OF-NETWORK ⁴
DEDUCTIBLE ¹	\$1,500/employee \$3,000/employee +1 or more	\$3,000/employee \$6,000/employee +1 or more
OUT-OF-POCKET MAXIMUM ²	\$3,500/employee \$6,550/employee +1 or more	No maximum
OFFICE VISITS	Deductible, then 20%	Deductible, then 50%
URGENT CARE		Deductible, then 20%
EMERGENCY ROOM		
WELLNESS SERVICES (ADULT/CHILD)	No deductible, \$0	Deductible, then 50%
TELEHEALTH (TELADOC)	No deductible, \$0	Not available
AMBULATORY SURGICAL CENTER	Deductible, then 20%	Deductible, then 50%
NON-HOSPITAL INFUSION CENTER		
NON-HOSPITAL RADIOLOGY CENTER		
NON-HOSPITAL LAB/PATHOLOGY		
HOSPITAL RADIOLOGY		
HOSPITAL LAB/PATHOLOGY		
AMBULANCE		
INPATIENT/OUTPATIENT HOSPITAL		
OUTPATIENT LAB AND X-RAY (INCLUDING MRI, PET, AND CT)		
OUTPATIENT BEHAVIORAL VISIT		

PRESCRIPTIONS

Except for preventive medications, you must meet your annual medical deductible before the following payment schedule applies³

RETAIL (30-day supply)

- Generic: \$10
- Preferred: \$60
- Non-preferred: \$110
- Specialty: 50% (maximum of \$150)

MAIL ORDER (90-day supply)

- Generic: \$20
- Preferred: \$120
- Non-preferred: \$220

¹This plan has a non-embedded deductible and out-of-pocket maximum. This means that families enrolling in the plan will need to meet the entire family deductible before the plan pays benefits for any member of the family (other than preventive/wellness care). It also means that the out-of-pocket maximum applies to the family as a whole rather than to individual covered family members. All benefits are subject to the deductible, unless noted otherwise.

²The out-of-pocket maximum includes deductibles, copayments, and coinsurance for all medical and prescription plan benefits.

³You must meet the annual medical plan deductible before the plan pays a prescription drug benefit, with the exception of certain preventive medications not subject to the deductible. For a detailed list of medications that are exempt from this rule under the HDHP plans, visit MaxorPlus.com.

⁴The in-network and out-of-network deductibles and out-of-pocket maximums are separate. This means that amounts applied toward the in-network deductible and out-of-pocket maximum do not also apply toward the out-of-network deductible and out-of-pocket maximum. Similarly, amounts applied toward the out-of-network deductible and out-of-pocket maximum do not also apply toward the in-network deductible and out-of-pocket maximum.

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\$5,000 HDHP

BENEFIT OVERVIEW

	IN-NETWORK ⁴	OUT-OF-NETWORK ⁴
DEDUCTIBLE ¹	\$5,000/employee \$10,000/employee +1 or more	\$10,000/employee \$20,000/employee +1 or more
OUT-OF-POCKET MAXIMUM ²	\$6,450/employee \$12,900/employee +1 or more	No maximum
OFFICE VISITS	Deductible, then 20%	Deductible, then 50%
URGENT CARE		
EMERGENCY ROOM		Deductible, then 20%
WELLNESS SERVICES (ADULT/CHILD)	No deductible, \$0	Deductible, then 50%
TELEHEALTH (TELADOC)	No deductible, \$0	Not available
AMBULATORY SURGICAL CENTER	Deductible, then 20%	Deductible, then 50%
NON-HOSPITAL INFUSION CENTER		
NON-HOSPITAL RADIOLOGY CENTER		
NON-HOSPITAL LAB/PATHOLOGY		
HOSPITAL RADIOLOGY		
HOSPITAL LAB/PATHOLOGY		
AMBULANCE		
INPATIENT/OUTPATIENT HOSPITAL		
OUTPATIENT LAB AND X-RAY (INCLUDING MRI, PET, AND CT)		
OUTPATIENT BEHAVIORAL VISIT		

PRESCRIPTIONS

Except for preventive medications, you must meet your annual medical deductible before the following payment schedule applies³

RETAIL (30-day supply)	<ul style="list-style-type: none"> Generic: \$10 Preferred: \$60 Non-preferred: \$110 Specialty: 50% (maximum of \$150)
MAIL ORDER (90-day supply)	<ul style="list-style-type: none"> Generic: \$20 Preferred: \$120 Non-preferred: \$220

¹This plan has an embedded individual deductible and out-of-pocket maximum. This means that although a deductible and out-of-pocket maximum apply to the family as a whole, no individual will be responsible for more than his/her individual deductible before the plan pays benefits for that person, and no individual will be responsible for more than his/her individual out-of-pocket maximum. All benefits are subject to the deductible, unless otherwise noted. The medical plan deductible does not apply to retail and mail order prescription drug copays.

²The out-of-pocket maximum includes deductibles, copayments, and coinsurance for all medical and prescription plan benefits.

³You must meet the annual medical plan deductible before the plan pays a prescription drug benefit, with the exception of certain preventive medications not subject to the deductible. For a detailed list of medications that are exempt from this rule under the HDHP plans, visit MaxorPlus.com.

⁴The in-network and out-of-network deductibles and out-of-pocket maximums are separate. This means that amounts applied toward the in-network deductible and out-of-pocket maximum do not also apply toward the out-of-network deductible and out-of-pocket maximum. Similarly, amounts applied toward the out-of-network deductible and out-of-pocket maximum do not also apply toward the in-network deductible and out-of-pocket maximum.

Please note: Information provided above may be subject to change at any time.

MORE BENEFITS WITH YOUR BENEFITS



HEALTH SAVINGS ACCOUNT (HSA)

If you enroll in a high deductible health plan (HDHP), you are eligible to open a health savings account with HealthEquity. An HSA is a personal savings account that lets you set aside pre-tax money from your paycheck to use on qualified medical expenses. Some examples of qualified expenses include deductibles and copays, doctor's office visits, prescription drugs, vaccines and screenings, and more! For a complete list, visit learn2.healthequity.com/kairos/qme.

Once you receive your debit card from HealthEquity, you'll be able to use your account. New cards are issued only to first-time enrollees (or if an existing card expires). Because it's your personal account, please contact HealthEquity if you need a replacement debit card.

HSA Advantages



Triple Tax Benefit

Contributions are tax deductible; the funds grow with no tax liability; and money used for health expenses is not taxed upon withdrawal.



It's Yours Forever

The money in your HSA rolls over every year and is yours to keep, even if you leave your employer.



Grow and Save

You can invest the funds, and your earnings grow tax-free. After age 65, you can use the HSA like a traditional retirement account.

YOU'RE ELIGIBLE FOR AN HSA IF:

- ☐ You're enrolled in a qualified high deductible health plan.
- ☐ You aren't enrolled in Medicare or another non-qualified health care plan.
- ☐ You're not also covered by a spouse's non-HDHP employer plan.
- ☐ You can't be claimed as a dependent on someone else's tax return.

HOW MUCH CAN YOU CONTRIBUTE?

TIER	MAXIMUM AMOUNT
INDIVIDUAL	\$3,850
FAMILY	\$7,750
AGE 55+	Additional \$1,000



*Learn how to
maximize your HSA*



You may contribute the maximum amount stated on a calendar year basis, or January 1 to December 31. This is a little different from the Kairos plan year, which runs from July to June. You are responsible for calculating and verifying that your contributions, including any employer contributions, don't exceed the maximum annual amount.

BASIC LIFE AND AD&D INSURANCE

Your employer provides eligible employees with basic life and AD&D in the amount of \$50,000. This benefit is at no cost to you, and enrollment is automatic.

Once you reach age 65, the original amount reduces to \$32,500, and then reduces again to \$25,000 at age 70.

When enrolling, you must designate a beneficiary. You may select more than one beneficiary and can make changes anytime by contacting your employer.

SUPPLEMENTAL LIFE AND AD&D INSURANCE

You have the opportunity to purchase additional life insurance coverage for yourself, your eligible spouse, and your dependent children. You are responsible for paying the cost of this benefit, as stated in the plan summary.

Unlike basic life insurance, your supplemental life insurance amount will not reduce with age. However, the amount you pay out of pocket will increase as you age.

SUPPLEMENTAL COVERAGE AMOUNTS

	YOU	YOUR SPOUSE	YOUR CHILDREN
AVAILABLE AMOUNTS	\$10,000–\$500,000 in increments of \$10,000 Cannot exceed 5 times your annual salary	\$10,000–\$250,000 in increments of \$10,000 Cannot exceed the combined amount of your basic life and supplemental life benefits	Up to 15 days old: \$1,000 15 days to 26 years: \$2,000–\$10,000 in increments of \$2,000
GUARANTEED ISSUE AMOUNT	\$150,000	\$30,000	\$10,000

NEW FOR 2023-2024: Existing Kairos employees may now elect or increase their supplemental life up to the guaranteed issue amount without completing EOI. (See definitions below.)

DEFINITIONS

The guaranteed issue amount, sometimes referred to as “non-medical maximum,” is a set amount of voluntary life insurance guaranteed to first-time enrollees that does not require evidence of insurability (EOI).

EOI is an application process that requires you to complete a statement of health (SOH) form on your medical history in order to be approved for the life insurance amount requested. EOI is required for individuals enrolling above the guaranteed issue amount.

Please pay close attention during enrollment to determine if an SOH is needed.



WORKSITE BENEFITS

Worksite benefits offered through MetLife are intended to offset out-of-pocket medical expenses. This is another layer to your medical insurance that pays you a lump sum cash benefit. You and your eligible spouse/dependents can enroll in these benefits but must enroll in the same plans—for example, you may not enroll in accident coverage for yourself and critical illness coverage for your dependents.

There are 3 plans to choose from. Pick one or pick them all.

	HOSPITAL INDEMNITY	CRITICAL ILLNESS	ACCIDENT
OVERVIEW	Cash benefit for hospitalization services	Cash benefit for covered critical illnesses NOTE: <i>Pre-existing condition limitations apply</i>	Cash benefit for injuries in a covered accident NOTE: <i>Benefits reduce by 25% at age 65, and 50% at 70.</i>
BENEFITS	Admission: \$500 ICU admission: \$500 Confinement: \$200/day, up to 15 days ICU confinement: \$200/day, up to 15 days Inpatient rehab: \$200/day, up to 15 days	3 critical illness amounts to choose from: \$10,000 \$20,000 \$30,000 <i>Your spouse and dependent children receive 50% of your initial benefit</i>	Injury: \$50-\$10,000 Medical services/treatment: \$25-\$2,000 Hospital (accident): \$200-\$2,000 Accidental death: \$50,000 Dismemberment: \$500-\$50,000 Lodging: \$200/night, up to 30 nights

New for 2023-2024: Hospital indemnity no longer has benefit reductions with increased age. Critical illness now covers hospitalization for COVID-19 for 5 consecutive days. Accident insurance added a 25% benefit for organized sports activity.

Refer to the plan summaries for more information about these changes and detailed benefit information.

HEALTH SCREENING BENEFITS AVAILABLE

For each enrolled worksite benefit, MetLife will pay you and your enrolled dependents \$50 per calendar year for completing a covered screening/test and submitting the information to MetLife.

Examples of covered screenings include: a blood test to determine total cholesterol, an endoscopy, or colonoscopy. (Refer to the plan document for more services.)

When you're ready to claim your \$50:

1. Call 877.638.7868.
2. Provide a few details, including: your doctor's contact information; the screening/test and date it was completed; and address where the screening/test was performed.
3. Receive your free \$50.

PREPAID LEGAL COVERAGE

Our legal plans through MetLife provide access to a national network of over 17,000 attorneys to help navigate important life events. Through the program, you can participate in telephone and office consultations with attorneys on a broad range of legal issues.

PREPAID LEGAL ADVANTAGES

- ✓ Telephone advice and office consultation on an unlimited number of legal matters (exclusions may apply)
- ✓ Access to attorneys in person or by phone, email, or mobile app
- ✓ Money-back guarantee
- ✓ No deductibles or copays
- ✓ No claim forms
- ✓ No usage limits

Prepaid legal is here to help you with:



Getting married and starting a family



Buying or selling your home



Sending kids off to college

Pick a plan that suits your needs.

	LOW PLAN	HIGH PLAN (In addition to Low Plan features)
COVERED SERVICES	<ul style="list-style-type: none">• Identity theft defense• Tenant negotiations• Foreclosures and mortgages• Powers of attorney (health care, financial, child care, immigration)• Simple or complex wills• Disputes over consumer goods• Defense of traffic tickets	<ul style="list-style-type: none">• Personal bankruptcy• Tax audit representation• Refinancing and home equity loan• Revocable and irrevocable trusts• Civil litigation defense• Juvenile court defense• Adoption

Exclusions: DUI, divorce, felonies, work-related matters, pre-existing legal matters

IDENTITY THEFT PROTECTION

Protecting your personal information is more important than ever. To help our members reduce the risk of identity theft, Kairos offers a comprehensive benefits package through Aura.

You have the option to enroll in one of three plans offered. The monthly contributions will be deducted from your paycheck.

SEPARATE ENROLLMENT STEP REQUIRED. Once enrolled, you will receive an email from Aura with a link and instructions for completing your registration. You must complete your election by the end of your open enrollment period. Once you make your election, you will not be able to change your plan.

Choose the plan that's right for you.

	TOTAL	PREMIER	ULTIMATE
NEAR REAL-TIME ALERTS	✓	✓	✓
AUTO-ON MONITORING	✓	✓	✓
HIGH-RISK TRANSACTION MONITORING	✓	✓	✓
ADDRESS MONITORING	✓	✓	✓
CRIMINAL RECORD MONITORING	✓	✓	✓
DARK WEB MONITORING	✓	✓	✓
CREDIT SCORE TRACKER	✓	✓	✓
RISK MANAGEMENT SCORE	✓	✓	✓
SEX OFFENDER MONITORING	✓	✓	✓
\$1,000,000 IDENTITY THEFT INSURANCE	✓	✓	✓
CREDIT AND DEBIT CARD MONITORING		✓	✓
SOCIAL INSIGHT REPORT		✓	✓
BANK ACCOUNT TRANSACTION MONITORING		✓	✓
ROBO-CALL/ROBO-TEXT PROTECTION			✓
JUNK EMAIL/JUNK MAIL PREVENTION			✓

Refer to plan summary for a complete list of covered services.

PET INSURANCE

Pet Insurance reimburses you for eligible vet expenses, up to \$7,500 per year.

The My Pet Protection plans from Nationwide help you provide your pets with the best care possible:

- ✓ **GET CASH BACK ON VET BILLS**
Choose your reimbursement level of 50% or 70%.
- ✓ **EXCLUSIVE TO YOU**
This offer is exclusive to Kairos members.
- ✓ **SAME PRICE FOR PETS OF ALL AGES**
Your rate won't go up because your pet had a birthday.
- ✓ **USE ANY VET, ANYWHERE**
No networks, no pre-approvals.

To enroll your cat or dog, visit petinsurance.com/kairoshealthaz.

To enroll your bird, rabbit, reptile, or other exotic pet, call 877.738.7874



IMPORTANT:
This benefit is not deducted from your paycheck. You will be responsible for paying the monthly premium directly to Nationwide.



THIS GUIDE IS INTENDED ONLY AS A BRIEF DESCRIPTION OF YOUR PLAN BENEFITS

This guide attempts to describe important details and changes to the Kairos health plans in a clear, simple, and concise manner. If there is a conflict between the guide and the wording of plan documents, the plan documents will govern. Kairos retains the right to change, modify, suspend, interpret, or cancel some or all of the benefits or services at any time.

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

If you or your eligible dependents are currently Medicare-eligible or will become Medicare-eligible during the next 12 months, be sure you understand whether the prescription drug coverage that you elect through the pool is or is not creditable with (as valuable as) Medicare's prescription drug coverage.

Kairos has determined that prescription drug coverage under the following prescription drug plan options is creditable: Core Plan; Copay Plan; \$1,200 PPO; \$1,500 HDHP; \$2,500 HDHP; and \$5,000 HDHP.

If you have questions about what this means for you, review the plan's Medicare Part D Notice of Creditable Coverage, which is available from Kairos at 888.331.0222.

PRIVACY NOTICE REMINDER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own health care information.

This plan's HIPAA privacy notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this notice when you enroll in the plan. You can also request another copy of the notice from Kairos.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- all stages of reconstruction of the breast on which the mastectomy was performed;

- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

Plan limits, deductibles, copayments, and coinsurance apply to these benefits. For more information on WHCRA benefits, contact Kairos at 888.331.0222.

MID-YEAR CHANGES TO YOUR HEALTH CARE BENEFIT ELECTIONS

IMPORTANT: After this open enrollment period is completed, generally you will not be permitted to change your benefit elections or add/delete dependents until next year's open enrollment, unless you have a special enrollment event or a mid-year change-in-status event as outlined below:

Special enrollment event: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 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 31 days after the marriage, birth, adoption, or placement for adoption.

You and your dependents may also enroll in this plan if you (or your dependents):

- have a change in number or status of dependents (e.g., birth, adoption, death);
- have a change in employee's/spouse's/dependent's employment status, work schedule, or residence that affects eligibility for benefits;
- have a Qualified Medical Child Support Order (QMCSO);
- have a change in entitlement to or loss of eligibility for Medicare or Medicaid;
- experience certain changes in the cost of coverage, composition of coverage, or curtailment of coverage of the employee's or spouse's plan;
- have coverage through Medicaid or a State Children's Health Insurance Program (S-CHIP) and you (or your dependents)

lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or S-CHIP coverage ends;

- become eligible for a premium assistance program through Medicaid or S-CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact Kairos at 888.331.0222.

Mid-year change-in-status event: Because Kairos pre-taxes benefits, we are required to follow Internal Revenue Service (IRS) regulations regarding whether and when benefits can be changed in the middle of a plan year. The following events may allow certain changes in benefits mid-year, if permitted by the IRS and your employer's respective Section 125 plan, which provides final authority:

- change in legal marital status (e.g., marriage, divorce/legal separation, death);
- change in coverage of the employee's or spouse's plan; and
- changes consistent with special enrollment rights and FMLA leaves.

You must notify the plan in writing within 31 days of the mid-year change-in-status event by contacting Kairos at 888.331.0222. The plan will determine if your change request is permitted, and if so, changes will become effective prospectively on the first day of the month following the approved change-in-status event (except for the case of newborn and adopted children, who are covered retroactively to the date of birth, adoption, or placement for adoption).

Losing medical coverage through the Health Insurance Marketplace is not considered a qualified life event with Kairos, and you will not be allowed to join the plan mid-year. However, you can drop your Kairos medical coverage to join the Marketplace plan mid-year. You will be required to provide proof of coverage within 31 days of your enrollment.

PAPERWORK REDUCTION ACT STATEMENT

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

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

DIRECT ACCESS TO PRIMARY CARE PROVIDER (PCP) AND OB/GYN PROVIDER

The medical plans offered by Kairos do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider; however, payment by the plan may be less for the use of a non-network provider.

You also do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care

professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services; following a pre-approved treatment plan; or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kairos at 888.331.0222.

COBRA COVERAGE REMINDER

In compliance with a provision of federal law referred to as COBRA continuation coverage, this plan offers its eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events).

A COBRA general notice will be mailed to all eligible employees within 90 days of their effective date. Qualified beneficiaries are entitled to elect COBRA coverage when qualifying events occur and, as a result of the qualifying event, coverage for that qualified beneficiary ends. Qualified beneficiaries who elect COBRA continuation coverage must pay for it at their own expense.

Qualifying event examples include termination of employment for any reasons other than gross misconduct, reduction in hours of work making the employee ineligible for coverage, death of the employee, divorce/legal separation, or a child ceasing to be an eligible dependent child.

In addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. You may wish to seek coverage through the Health Insurance Marketplace, for example. (See www.healthcare.gov.) In the Marketplace, you could be

eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible—such as a spouse's plan—if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

The maximum period of COBRA coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

In order to have the opportunity to elect COBRA coverage following a divorce/legal separation or a child ceasing to be a dependent child under the plan, you and/or a family member must inform the plan in writing of that event no later than 60 days after the event occurs. The notice should be sent to Kairos via first class mail, and should include the employee's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents).

If you have questions about COBRA, contact Kairos at 888.331.0222.

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 the 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 877.KIDSNOW 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 866.444.EBSA (3272).

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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 1, 2022. Contact your state for more information on eligibility.

ALABAMA – Medicaid Website: http://myalhiipp.com/ Phone: 1-855-692-5447	CALIFORNIA – Medicaid Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hiipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hiipp@dhcs.ca.gov
ALASKA – Medicaid The AK Health Insurance Premium Payment Program Website: http://myakhiipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid Website: http://myarhiipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	FLORIDA – Medicaid Website: https://www.flmedicaidtorecovery.com/flmedicaidtorecovery.com/hiipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hiipp 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	MASSACHUSETTS – Medicaid and CHIP Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hiip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	MINNESOTA – Medicaid Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.isp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki) Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hiipp HIPP Phone: 1-888-346-9562	MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hiipp.htm Phone: 573-751-2005
KANSAS – Medicaid Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	MONTANA – Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.kv.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@kv.gov KCHIP Website: https://kidshealth.kv.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.kv.gov	NEBRASKA – Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

LOUISIANA – Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	NEW HAMPSHIRE – Medicaid Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.nifamilycare.org/index.html CHIP Phone: 1-800-701-0710	SOUTH DAKOTA – Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	TEXAS – Medicaid Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	UTAH – Medicaid and CHIP Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	VERMONT– Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	VIRGINIA – Medicaid and CHIP Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	WASHINGTON – Medicaid Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	WEST VIRGINIA – Medicaid and CHIP 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)
RHODE ISLAND – Medicaid and CHIP Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)	WISCONSIN – Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid Website: https://www.scdhhs.gov Phone: 1-888-549-0820	WYOMING – Medicaid Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 1, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
cms.hhs.gov
877.267.2323, menu option 4, ext. 61565