2021-2022 BENEFITS

MINGUS UNION HSD NO. 4

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How to use this guide

This guide provides a summary of benefit options to help you make the right decisions for you and your family.

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 VOLUNTARY PRODUCTS
If applicable, review and decide whether to elect any voluntary products.

Scan with your phone

Learn a little more about your Kairos team: svc.kairoshealthaz.org/Home/WhoIsKairos

WHAT'S NEW?

1. Kairos's medical network is changing to UnitedHealthcare (UHC), with UMR as the medical claims payor/processor.
2. New medical/prescription ID cards will be sent to everyone this year. Be on the lookout.
3. Kairos and UMR are teaming up to provide a new and improved health care advocacy program. We can't wait to show you!
4. Teladoc is taking over as the telehealth provider, giving you access to general medicine, behavioral health care—*and now*—dermatology services.
5. ComPsych will be the new employee assistance program (EAP), giving 24/7 access to counseling and work-life resources.
6. Prescription copays are changing. Refer to the medical plan pages for the new amounts.
7. The 90-day prescription option is being eliminated through retail pharmacies, but you'll still have access to 90-day prescriptions through mail-order.
8. The HDHP preventive prescription list is being modified to allow for generic prescriptions only.
9. We have extended no cost-share preventive service coverage to conditions like diabetes and asthma.
10. We're eliminating age restrictions on mammograms and colonoscopies. This means more wellness services for you and your family.
11. Allowable HSA contributions are going up, so you can save more money this year. See the HSA section for more info.

Contact Info

Kairos Member Services
for general plan questions
888.331.0222
svc.kairoshealthaz.org

UMR
for questions about medical information and ID cards
844.212.6811
umr.com

ComPsych
for questions about the employee assistance program
833.955.3386
guidanceresources.com

MaxorPlus
for questions about prescription drugs
800.687.0707
maxorplus.com

WHO'S ELIGIBLE?

- Full-time employees working at least 30 hours per week
- Part-time employees working at least 20 hours per week, 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

THE ELECTIONS MADE DURING THIS ENROLLMENT PERIOD ARE EFFECTIVE FROM

July 1, 2021 to June 30, 2022

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.

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

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

You have 31 days from the time of the qualifying event to make changes to your coverage.

Losing medical coverage through the Health Insurance Marketplace is not considered a qualifying event.

If you have questions about your eligibility or mid-year changes, contact your employer or Kairos Member Services.

WHAT DOES IT ALL MEAN?!?

Let’s break down some health insurance terms and make this easy.

PLAN YEAR DEDUCTIBLE

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

EMBEDDED DEDUCTIBLE

This is a deductible arrangement under which individual family members have their own deductibles—plus 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

Under this deductible arrangement, 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)

This is a 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.

IN-NETWORK VS. OUT-OF-NETWORK

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

Check out our Medical Benefits 101 video:
svc.kairoshealthaz.org/home/Medical_Benefits_101

COINSURANCE

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

EXAMPLE: Let’s say you’ve met your deductible. Your recent doctor’s visit was $100, and your coinsurance is 20%. This means your insurance will pay $80, and you owe the other $20.

OUT-OF-POCKET MAXIMUM

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

MEDICAL NETWORK

Call 844.212.6811 or visit umr.com

MEDICAL NETWORK

Starting July 1, 2021, UnitedHealthcare (UHC) will provide the Kairos medical network, with UMR as the claims administrator.

Be on the lookout!

What's this mean for you?

Access to over 600,000 providers across the country

New claims processing contacts

New and improved medical/Rx ID cards

To find an in-network provider, visit https://go.umr.com/KairosHealthArizona

PREVENTIVE BENEFITS

We want to keep you healthy. So, the Kairos plan covers preventive care services **for free** when you visit an in-network provider.

Examples of preventive benefits include:

- Annual wellness visits
- Prostate screenings
- Annual flu shots
- Hearing exams
- Well child visits
- Mammogram screenings
- Colonoscopy screenings
- Cancer screenings
- Generic contraceptives
- Blood pressure tests

With UMR's member portal, you'll be able to:

- Order new ID cards
- View claims information and EOBs
- Use the health cost estimator tool
- And so much more!

Start browsing at umr.com.

You can see a full list of preventive services at:
www.healthcare.gov/coverage/preventive-care-benefits/

PRESCRIPTION BENEFITS

Call 800.687.0707 or visit maxor.com

PRESCRIPTION BENEFITS

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

To manage your prescription benefits, register for the MaxorPlus Member Portal. Once there, you can do things like:

Locate the closest network pharmacy

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

Sign up for mail-order

MYMAXORLINK DISCOUNT PROGRAM

Get the most from your pharmacy benefits and register for myMaxorLink. Once enrolled, you'll automatically receive information on lower-cost prescriptions, reminders specific to your coverage, and other important health updates. This is a great discount savings resource!

To enroll, call 888.596.0723 or go to mymaxorlink.com/maxorplus. It's as simple as that. And it's free to enroll!

Important tip!

Prescriptions can be expensive. Don't let them be.

- ✓ Take the generic option when available.
- ✓ Shop around for lower cost alternatives using the Maxor copay calculator.
- ✓ Sign up for myMaxorLink and let it do the work for you.

BENEFITS WITH YOUR BENEFITS

With Kairos, you get more than just the basic benefits. Take advantage of all the resources available to you, like these:

TELADOC® TELEHEALTH

With Teladoc, you can use your telephone or computer to conduct a live virtual visit with a board-certified medical professional—any day, anytime, anywhere.

You'll get fast help for non-emergency matters like:

- ✓ Cold and flu symptoms
- ✓ Skin irritations
- ✓ Stomach bugs
- ✓ Headache
- ✓ Pink eye
- ✓ Sinus infection
- ✓ Sore throat

You'll also have access to behavioral health services and dermatology services!

Questions?

Call 800.835.2362
or visit teladoc.com

ComPsych® GuidanceResources® Worldwide

COMPSYCH® EMPLOYEE ASSISTANCE PROGRAM

ComPsych offers 24-hour access to confidential counseling services that can help with a variety of everyday issues and challenges. Professional advisors are available to help you and your family with:

- ✓ Stress, anxiety, and minor depression management
- ✓ Family and relationship matters
- ✓ Substance abuse
- ✓ Childcare and elder care resources
- ✓ Legal and financial information and resources
- ✓ Will preparation services

Coverage includes up to 6 one-on-one counseling sessions per family member, per issue, per year at no cost to you. And first responders get up to 12 one-on-one counseling sessions for a traumatic on-the-job event.

Questions?

Call 833.955.3386
or visit
guidanceresources.com
Web ID: KairosEAP

AND NOW WHAT YOU'VE BEEN WAITING FOR...

MEDICAL PLANS!

CORE PLAN
BENEFIT OVERVIEW

	IN-NETWORK[3]	OUT-OF-NETWORK[3]
PLAN YEAR DEDUCTIBLE[1]	$500/employee $1,000/employee +1 $1,500/employee +2 or more	$1,000/employee $2,000/employee +1 $3,000/employee +2 or more
OUT-OF-POCKET MAXIMUM[2]	$4,500/employee $9,000/employee +1 or more	No maximum
OFFICE VISIT	Plan pays 80%, after deductible	Plan pays 50%, after deductible
WELL ADULT CARE	Plan pays 100%, no deductible	Plan pays 50%, after deductible
WELL CHILD CARE	Plan pays 100%, no deductible	Plan pays 50%, after deductible
TELEHEALTH (TELADOC)	Plan pays 100%, no deductible	N/A
EMERGENCY ROOM	Plan pays 80%, after deductible	Plan pays 80%, after deductible
URGENT CARE	Plan pays 80%, after deductible	Plan pays 50%, after deductible
INPATIENT HOSPITAL	Plan pays 80%, after deductible	Plan pays 50%, after deductible
OUTPATIENT HOSPITAL	Plan pays 80%, after deductible	Plan pays 50%, after deductible
OUTPATIENT LAB AND X-RAY (INCLUDING MRI, PET, AND CT)	Plan pays 80%, after deductible	Plan pays 50%, after deductible
OUTPATIENT BEHAVIORAL VISIT	Plan pays 80%, after deductible	Plan pays 50%, after deductible

RETAIL PRESCRIPTION DRUGS (30-day supply)	**You pay:** • Generic: $10 • Preferred: $60 • Non-preferred: $110 • Specialty: 50% (maximum of $150)
MAIL ORDER DRUGS (90-day supply)	**You pay:** • Generic: $25 • Preferred: $120 • Non-preferred: $220

[1]This 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. This is true whether or not the family deductible has been met. The deductible must be met before benefits are payable. All benefits are subject to the deductible, unless otherwise noted. The medical plan deductible need not be met for retail and mail order prescription drugs.

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

[3]The 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.

Disclaimer: Information provided above may be subject to change.

COPAY PLAN
BENEFIT OVERVIEW

	IN-NETWORK[3]	OUT-OF-NETWORK[3]
PLAN YEAR 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 VISIT	$20 copay: primary care physician $40 copay: specialist	Plan pays 50%, after deductible
WELL ADULT CARE	Plan pays 100%, no deductible	Plan pays 50%, after deductible
WELL CHILD CARE	Plan pays 100%, no deductible	Plan pays 50%, after deductible
TELEHEALTH (TELADOC)	Plan pays 100%, no deductible	N/A
URGENT CARE	$40 copay	Plan pays 50%, after deductible
EMERGENCY ROOM	Plan pays 80%, after deductible	Plan pays 80%, after deductible
INPATIENT HOSPITAL	Plan pays 80%, after deductible	Plan pays 50%, after deductible
OUTPATIENT HOSPITAL	Plan pays 80%, after deductible	Plan pays 50%, after deductible
OUTPATIENT LAB AND X-RAY (INCLUDING MRI, PET, AND CT)	Plan pays 80%, after deductible	Plan pays 50%, after deductible
OUTPATIENT BEHAVIORAL VISIT	Plan pays 80%, after deductible	Plan pays 50%, after deductible

RETAIL PRESCRIPTION DRUGS (30-day supply)	**You pay:** • Generic: $10 • Preferred: $60 • Non-preferred: $110 • Specialty: 50% (maximum of $150)
MAIL ORDER DRUGS (90-day supply)	**You pay:** • Generic: $25 • Preferred: $120 • Non-preferred: $220

[1]This 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. This is true whether or not the family deductible has been met. Additionally, under the Copay Plan, certain services are covered by a copay. All other services are subject to the deductible unless otherwise noted. For these services, the deductible must be met before benefits are payable. The medical plan deductible need not be met for retail and mail order prescription drugs.

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

[3]The 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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$1,500 HDHP ($3,000 FAMILY*) BENEFIT OVERVIEW	IN-NETWORK[3]	OUT-OF-NETWORK[3]
PLAN YEAR 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 VISIT	Plan pays 80%, after deductible	Plan pays 50%, after deductible
WELL ADULT CARE	Plan pays 100%, no deductible	Plan pays 50%, after deductible
WELL CHILD CARE	Plan pays 100%, no deductible	Plan pays 50%, after deductible
TELEHEALTH (TELADOC)	Plan pays 100%, no deductible	N/A
EMERGENCY ROOM	Plan pays 80%, after deductible	Plan pays 80%, after deductible
URGENT CARE	Plan pays 80%, after deductible	Plan pays 50%, after deductible
INPATIENT HOSPITAL	Plan pays 80%, after deductible	Plan pays 50%, after deductible
OUTPATIENT HOSPITAL	Plan pays 80%, after deductible	Plan pays 50%, after deductible
OUTPATIENT LAB AND X-RAY (INCLUDING MRI, PET, AND CT)	Plan pays 80%, after deductible	Plan pays 50%, after deductible
OUTPATIENT BEHAVIORAL VISIT	Plan pays 80%, after deductible	Plan pays 50%, after deductible

RETAIL PRESCRIPTION DRUGS	You pay:
After deductible is met (30-day supply)[4]	• Generic: $10 • Preferred: $60 • Non-preferred: $110 • Specialty: 50% (maximum of $150)
MAIL ORDER DRUGS	**You pay:**
After deductible is met (90-day supply)[4]	• Generic: $25 • Preferred: $120 • Non-preferred: $220

*This 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 for preventive/wellness care).

[1]The deductible must be met before the HDHP plan pays benefits. All benefits are subject to the deductible, unless otherwise noted.

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

[3]The 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.

[4]The annual deductible must be met before the plan pays a prescription drug benefit, with the exception of certain preventive medications. For a detailed list of these medications, visit svc.kairoshealthaz.org.

Disclaimer: Information provided above may be subject to change.

$2,500 HDHP
($5,000 FAMILY*)
BENEFIT OVERVIEW

	IN-NETWORK[3]	OUT-OF-NETWORK[3]
PLAN YEAR DEDUCTIBLE[1]	$2,500/employee $5,000/employee +1 or more	$5,000/employee $10,000/employee +1 or more
OUT-OF-POCKET MAXIMUM[2]	$3,450/employee $6,550/employee +1 or more	No maximum
OFFICE VISIT	Plan pays 80%, after deductible	Plan pays 50%, after deductible
WELL ADULT CARE	Plan pays 100%, no deductible	Plan pays 50%, after deductible
WELL CHILD CARE	Plan pays 100%, no deductible	Plan pays 50%, after deductible
TELEHEALTH (TELADOC)	Plan pays 100%, no deductible	N/A
EMERGENCY ROOM	Plan pays 80% after deductible	Plan pays 80%, after deductible
URGENT CARE	Plan pays 80% after deductible	Plan pays 50%, after deductible
INPATIENT HOSPITAL	Plan pays 80% after deductible	Plan pays 50%, after deductible
OUTPATIENT HOSPITAL	Plan pays 80% after deductible	Plan pays 50%, after deductible
OUTPATIENT LAB AND X-RAY (INCLUDING MRI, PET, AND CT)	Plan pays 80% after deductible	Plan pays 50%, after deductible
OUTPATIENT BEHAVIORAL VISIT	Plan pays 80% after deductible	Plan pays 50%, after deductible

RETAIL PRESCRIPTION DRUGS After deductible is met (30-day supply)[4]	**You pay:** • Generic: $10 • Preferred: $60 • Non-preferred: $110 • Specialty: 50% (maximum of $150)
MAIL ORDER DRUGS After deductible is met (90-day supply)[4]	**You pay:** • Generic: $25 • Preferred: $120 • Non-preferred: $220

*This 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 for preventive/wellness care).

[1]The deductible must be met before the HDHP plan pays benefits. All benefits are subject to the deductible, unless otherwise noted.

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

[3]The 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.

[4]The annual deductible must be met before the plan pays a prescription drug benefit, with the exception of certain preventive medications. For a detailed list of these medications, visit svc.kairoshealthaz.org.

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$5,000 HDHP
BENEFIT OVERVIEW

	IN-NETWORK[3]	OUT-OF-NETWORK[3]
PLAN YEAR 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 VISIT	Plan pays 80%, after deductible	Plan pays 50%, after deductible
WELL ADULT CARE	Plan pays 100%, no deductible	Plan pays 50%, after deductible
WELL CHILD CARE	Plan pays 100%, no deductible	Plan pays 50%, after deductible
TELEHEALTH (TELADOC)	Plan pays 100%, no deductible	N/A
EMERGENCY ROOM	Plan pays 80%, after deductible	Plan pays 80%, after deductible
URGENT CARE	Plan pays 80%, after deductible	Plan pays 50%, after deductible
INPATIENT HOSPITAL	Plan pays 80%, after deductible	Plan pays 50%, after deductible
OUTPATIENT HOSPITAL	Plan pays 80%, after deductible	Plan pays 50%, after deductible
OUTPATIENT LAB AND X-RAY (INCLUDING MRI, PET, AND CT)	Plan pays 80%, after deductible	Plan pays 50%, after deductible
OUTPATIENT BEHAVIORAL VISIT	Plan pays 80%, after deductible	Plan pays 50%, after deductible

RETAIL PRESCRIPTION DRUGS After deductible is met (30-day supply)[4]	**You pay:** • Generic: $10 • Preferred: $60 • Non-preferred: $110 • Specialty: 50% (maximum of $150)
MAIL ORDER DRUGS After deductible is met (90-day supply)[4]	**You pay:** • Generic: $25 • Preferred: $120 • Non-preferred: $220

This 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.

[1]The deductible must be met before the HDHP plan pays benefits. All benefits are subject to the deductible, unless otherwise noted.

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

[3]The 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.

[4]The annual deductible must be met before the plan pays a prescription drug benefit, with the exception of certain preventive medications. For a detailed list of these medications, visit svc.kairoshealthaz.org.

Disclaimer: Information provided above may be subject to change.

MORE BENEFITS
WITH YOUR
BENEFITS

Call 866.346.5800 or visit healthequity.com

HEALTH SAVINGS ACCOUNT (HSA)

If you enroll in a high deductible health plan, you have the option of opening a health savings account with HealthEquity. An HSA is a personal savings account that you can use to pay for qualified health care expenses.

HSA Advantages

Triple Tax Benefit

Contributions are tax deductible; qualified medical expenses are tax-free; and funds grow with no tax liability.

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.

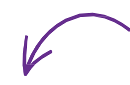
YOU'RE ELIGIBLE FOR AN HSA IF:

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

Discover the many uses for your HSA: https://learn.healthequity.com/qme/

HOW MUCH CAN YOU CONTRIBUTE?

COVERAGE TYPE	2021 CONTRIBUTION LIMIT
INDIVIDUAL	$3,600
FAMILY	$7,200
AGE 55+ CATCH-UP CONTRIBUTION	Additional $1,000



HSA increases for 2021

HSA contribution limits are determined on a calendar/tax-year basis. This means that the limits you see here apply to the January 1 through December 31 period. This is a little different from the Kairos plan year, which runs July 1 to June 30.

Learn how to maximize your HSA savings by watching our video, HSA Saves the Day: https://www.svc.kairoshealthaz.org/ResourceTraining/DownloadDoc/722

Kairos and HealthEquity do not provide legal, tax or financial advice. Please consult your personal tax advisor or legal counsel for this information.

Call 888.331.0222 or visit metlife.com

BASIC LIFE INSURANCE

Your employer provides eligible employees with life insurance coverage in the amount of $50,000 in the event of death or dismemberment. The plan also provides for an accelerated death benefit in the event of a terminal illness.

After you reach age 65, the policy amount is reduced by 35% to $32,500, and then reduced again at age 70 by 50%, to $25,000.

You must designate a beneficiary for the basic life insurance benefit. To update your beneficiary information, please contact your employer.

SUPPLEMENTAL LIFE INSURANCE

If eligible, you have the opportunity to purchase supplemental life insurance coverage for yourself and your eligible spouse and dependent children. The covered employee must elect supplemental life for him/herself to be eligible for supplemental spousal coverage. Note: The amount of coverage, once elected, will not automatically reduce with age. However, your premium will increase as you age.

MetLife provides extended support services such as travel assistance, will preparation, estate resolution, and grief counseling. Please contact Kairos for more information.

KAIROS OFFERS THE FOLLOWING SUPPLEMENTAL COVERAGE AMOUNTS

EMPLOYEE	$10,000–$500,000, not to exceed five times annual earnings (NOTE: Initial member enrollment provides up to $150,000 and is guaranteed issue.)
SPOUSE	$10,000–$250,000, not to exceed 100% of employee voluntary and basic life combined (NOTE: Initial member enrollment provides up to $30,000 and is guaranteed issue. Spousal rates are based on age of employee.)
CHILD (0–15 days)	$1,000
CHILD (15 days–26 years)	$2,000–$10,000, in $2,000 increments

Call 877.638.7868 or visit legalplans.com

METLIFE LEGAL SERVICES PLAN

Kairos's legal plan through MetLife provides access to a national network of over 17,000 attorneys to help navigate important life events such as buying a home or creating a will. Through the program, you can participate in telephone and office consultations with attorneys on a broad range of legal services.

The MetLaw advantage

- 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

LOW PLAN	HIGH PLAN (IN ADDITION TO LOW PLAN FEATURES)
Identity theft defense	Personal bankruptcy
Tenant negotiations/foreclosures	Tax audit representation
Powers of attorney, guardianship, conservatorship, demand letters, school hearings	Purchase or sale of a home/property
Disputes over consumer goods	Revocable and irrevocable trusts
Defense of traffic tickets	Civil litigation defense and pet liability
Elder care law	Juvenile court defense
	Adoption

Contact Kairos for a full listing of covered services, or visit our website at svc.kairoshealthaz.org.

Call 877.638.7868 or visit mybenefits.metlife.com

HOSPITAL INDEMNITY (worksite benefit)

Kairos's hospital indemnity plan through MetLife offers a cash benefit when you require hospitalization and are admitted to the hospital. The policy provides one cash benefit per hospital confinement, and cash benefits per day of hospitalization. There are no pregnancy or pre-existing condition exclusions. Benefits reduce by 25% at age 65, and by 50% at age 70.

BENEFIT TYPE	PLAN PAYS
HOSPITAL COVERAGE (SICKNESS OR ACCIDENT)	
ADMISSION (Payable once per calendar year)	$500 $500 (ICU)
CONFINEMENT (Paid per sickness)	$200 per day for up to 15 days $200 per day (ICU) for up to 15 days
OTHER BENEFITS	
HEALTH SCREENING BENEFIT (WELLNESS) (Payable once per covered person, per calendar year)	$50
INPATIENT REHABILITATION BENEFIT	$200 per day

Want a free $50? Just get an eligible health screening and submit your claim with MetLife. They'll send you $50. Easy as that!

HOW IT WORKS

On his way to work, Bill's car is hit by a large truck on the highway. Bill is immediately taken to the emergency room at a local hospital. Upon evaluation by the attending doctor, Bill is admitted to the Intensive Care Unit for close observation of trauma to his head and a fractured disk in his neck. After two days in the ICU, he is moved to a standard room and stays there for five more days. Bill is then transferred for inpatient care at a rehabilitation facility. His stay there is seven days. Bill would receive a lump-sum payment totaling $4,200.

COVERED EVENT	BENEFIT AMOUNT
Hospital admission	$500
ICU supplemental admission ICU	$500
Confinement for 2 days ICU	$800 ($400 per day)
Confinement for 5 days hospital	$1,000 ($200 per day)
Inpatient rehab unit	$1,400 ($200 per day)
	$4,200 Total

Call 877.638.7868
or visit
mybenefits.metlife.com

CRITICAL ILLNESS (worksite benefit)

Kairos's critical illness plan through MetLife can provide financial protection to help lessen the burden of large out-of-pocket costs for employees who suffer a critical illness.

COVERED PERSON	INITIAL BENEFIT	REQUIREMENT
EMPLOYEE	$10,000, $20,000, or $30,000	Coverage is guaranteed, provided you are actively at work.*
SPOUSE/DOMESTIC PARTNER	50% of the initial benefit	Coverage is guaranteed, provided you are actively at work and your spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the coverage certificate.*
DEPENDENT CHILD(REN)	50% of the initial benefit	Coverage is guaranteed, provided you are actively at work and your dependent is not subject to a medical restriction as set forth on the enrollment form and in the coverage certificate.*

OTHER BENEFITS	
HEALTH SCREENING BENEFIT (WELLNESS) (Payable once per covered person, per calendar year)	$50

*Coverage is guaranteed subject to terms and conditions, including pre-existing condition limitations.

HOW IT WORKS

John suffers a heart attack. Upon further examination, it is revealed that John also has a blocked coronary artery and needs to undergo heart surgery. He is diagnosed a year later with lung cancer. John had elected $10K in critical illness insurance, so he would receive:

COVERED EVENT	BENEFIT AMOUNT
Heart Attack	$10,000
CABG	$10,000
Lung Cancer	$10,000

The total benefit payout over the life of the policy would be $30K, which is the maximum benefit (300% of elected amount).

Call 877.638.7868 or visit mybenefits.metlife.com

ACCIDENT INSURANCE (worksite benefit)

Kairos's accident insurance plan through MetLife provides a financial cushion to absorb expenses like copays and deductibles. Benefits are paid regardless of medical insurance coverage, and benefit dollars can be spent as participants choose. Benefits reduce by 25% at age 65, and by 50% at age 70.

BENEFIT TYPE*	PLAN PAYS
AMBULANCE	$300–$1,000
EMERGENCY CARE	$50–$100
INPATIENT SURGERY	$200–$2,000
HOSPITAL ADMISSION	$1,000 (non ICU)–$2,000 (ICU) per accident
HOSPITAL CONFINEMENT	$200 per day (non ICU)—up to 31 days $400 per day (ICU)—up to 31 days
INPATIENT REHAB	$200 per day, up to 15 days per accident, not to exceed 30 days per calendar year
ACCIDENTAL DEATH Employee receives 100% of amount shown; spouse receives 50%, and children receive 20%.	$50,000 $150,000 for common carrier
DISMEMBERMENT, LOSS AND PARALYSIS	$500–$50,000 per injury
OTHER BENEFITS	
LODGING: Pays for lodging for companion up to 30 nights per calendar year	$200 per night, up to 30 nights; up to $6,000 in total lodging benefits available per calendar year
HEALTH SCREENING BENEFIT (WELLNESS) (Payable once per covered person, per calendar year)	$50

*Refer to the plan summary for a complete listing of covered accidents.

HOW IT WORKS

Kathy's daughter, Molly, plays soccer. During a recent game, Molly collided with an opposing player, was knocked unconscious, and was taken to the ER by ambulance. The ER doctor diagnosed a concussion and a broken tooth. He also ordered a CT scan. After thorough evaluation, Molly was released to her primary care physician for follow-up treatment, and her dentist repaired her broken tooth with a crown.

COVERED EVENT[1]	BENEFIT AMOUNT
Ambulance (ground)	$300
Emergency room	$100
Physical follow-up ($75 x 2)	$150
Medical testing	$200
Concussion	$400
Broken tooth (repaired by crown)	$200

Kathy would receive a lump-sum payment totaling $1,350.

[1] Covered services/treatments must be the result of a covered accident or sickness as defined in the group policy/certificate.

Call 855.443.7748 or visit identityguard.com

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 Identity Guard.

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

Once enrolled, you will receive an email from Identity Guard 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 Identity Guard plan.

Choose the plan that's right for you.

PRODUCT BENEFITS*	TOTAL	PREMIER	ULTIMATE
NEAR REAL-TIME ALERTS	✓	✓	✓
AUTO-ON MONITORING	✓	✓	✓
HIGH-RISK TRANSACTION MONITORING	✓	✓	✓
ADDRESS MONITORING	✓	✓	✓
DARK WEB MONITORING	✓	✓	✓
CREDIT AND DEBIT CARD MONITORING		✓	✓
CREDIT SCORE TRACKER	✓	✓	✓
RISK MANAGEMENT SCORE	✓	✓	✓
SEX OFFENDER MONITORING	✓	✓	✓
$1,000,000 IDENTITY THEFT INSURANCE	✓	✓	✓
SOCIAL INSIGHT REPORT		✓	✓
BANK ACCOUNT TRANSACTION MONITORING		✓	✓
ROBO-CALL/ROBO-TEXT PROTECTION			✓
CHILD IDENTITY PROTECTION	Included with family plan	Included with family plan	Included with family plan

*Refer to the plan summary for a complete listing of covered services by plan.

Call 877.738.7874 or visit petsnationwide.com

PET INSURANCE

Pet insurance pays, partly or in total, the cost of veterinary treatment for your ill or injured pet. The My Pet Protection plans from Nationwide help you provide your pets with the best care possible:

- Up to 90% cash back: Use any vet and get your choice of 90%, 70%, or 50% reimbursement on the bill.
- Open to all ages: No age limits or age-based premium increases.
- More than just accident & illness coverage: optional wellness coverage is available for spay/neuter, dental cleaning, exams, vaccinations, and more.
- Exclusive: Available only for employees, not to the general public.
- Easy enrollment: Just a few simple questions to get coverage.
- Bigger savings: Save an average of 40% over similar plans from other pet insurers.

To enroll in this benefit, please visit: petinsurance.com/kairoshealthaz

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

The 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 this 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; $1,500 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 healthcare 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):

- change in number or status of dependents (e.g., birth, adoption, death);
- 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; and
- 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 ebsa.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 healthcare 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. (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).

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, 2020.
Contact your state for more information on eligibility.

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 855.692.5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 800.221.3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 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: 855.692.6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 866.251.4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 877.357.3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 855.MyARHIPP (855.692.7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678.564.1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916.440.5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 877.438.4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 800.457.4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 800.338.8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 800.257.8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 800.694.3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 800.792.4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 Lincoln: 402.473.7000 Omaha: 402.595.1178
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603.271.5218 Toll free number for the HIPP program: 800.852.3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800.442.6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800.977.6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609.631.2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 800.701.0710

MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 800.862.4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 800.541.2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 800.657.3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919.855.4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573.751.2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 844.854.4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 888.365.3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 877.543.7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 800.699.9075	Website: http://www.greenmountaincare.org/ Phone: 800.250.8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 800.692.7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 800.432.5924 CHIP Phone: 855.242.8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 855.697.4347, or 401.462.0311 (Direct Rite Share Line)	Website: https://www.hca.wa.gov/ Phone: 800.562.3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 888.549.0820	Website: http://mywvhipp.com/ Toll-free phone: 855.MyWVHIPP (855.699.8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 888.828.0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 800.362.3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 800.440.0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2020, 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 & Medicaid Services
cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565