2019–2020
BENEFITS

UNION ELEMENTARY SCHOOL DISTRICT NO. 62

WE'VE GOT YOU COVERED

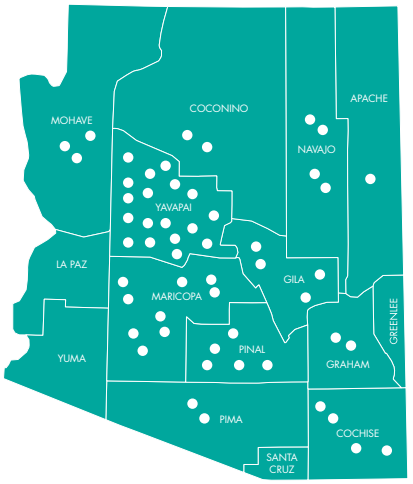
KAIROS
HEALTH ARIZONA, INC.

DO YOU KNOW KAIROS?

Kairos launched in 2017, determined to change the marketplace and provide a better healthcare solution for public entities. Kairos offered a fresh set of choices, and a sincere commitment to transparency, flexibility, and great service.

All of the benefits and services you've come to expect from your health plan are included with Kairos: medical, dental, vision, wellness, an employee assistance program, COBRA administration, a suite of ancillary products, and much more.

Welcome to the 2019/2020 program year. We look forward to serving you.



KAIROS
HEALTH ARIZONA, INC.

LET THE ADULTING BEGIN!

PLEASE REVIEW THIS GUIDE CAREFULLY, AND CONTACT YOUR BENEFITS DEPARTMENT IF YOU HAVE QUESTIONS

This guide presents benefit options and costs for the period from July 1, 2019 through June 30, 2020. It also outlines the steps you need to take to select and enroll in appropriate benefits for you and your dependents.

WHO SHOULD YOU CALL?

Contact our plan providers directly if you have questions or would like more detailed information about our plans. If you need further assistance regarding your benefits, contact your human resources or benefits department.

PLAN PROVIDERS	For Questions About...	Phone	Website
Blue Cross Blue Shield	Eligibility; benefits information; medical plan claims and appeals; precertification	844-817-4116	www.azblue.com
BlueCare Anywhere	Virtual physician visits	844-606-1612	www.bluecareanywhereaz.com
MaxorPlus Pharmacy Plan	Prescription drugs (retail and mail)	800-687-0707	www.maxorplus.com
BASIC	COBRA administration	800-372-3539	www.basiconline.com
EAP Preferred	Employee assistance program	800-327-3517	www.eappreferred.com
Kairos Health Arizona, Inc. (Kairos)	Plan administration and member services	888-331-0222	www.svc.kairoshealthaz.org

See ancillary summary pages for additional contact information.

A FEW CHANGES TO NOTE

ID CARDS AND ENROLLMENT

Following enrollment, new medical and pharmacy ID cards will be issued to all members. Please do not discard your old card(s) until you receive the new ID card(s).

Health savings account (HSA) cards and dental benefit cards will be issued to new members only.

Vision Service Plan (VSP) does not issue cards. Instead, you will need to provide the employee's social security number when receiving services.

Depending on your employer, you may be able to enroll for benefits online. Please contact your benefits representative for more details.

NEW PHARMACY SERVICES

We'll be working with a new pharmacy benefit manager, MaxorPlus, in year three. We think they're the best in the business—they're well known for cost-effectiveness, sky-high customer satisfaction, and great member engagement programs.

What can you expect from the new pharmacy program? Access to the same great pharmacies you already use, lower costs, and direct support to help you find the best options for you and your family.

As with any new prescription program, there is always the potential for changes affecting the medications you are currently taking. But you can be sure that the MaxorPlus program support team will work with you through this process. Simply go online at maxorplus.com to confirm your prescription availability and gather additional information. Don't wait!

Finally, if you have questions or need assistance, please contact Kairos Member Services.

OUT-OF-NETWORK EMERGENCY ROOM CHARGES

Out-of-network emergency rooms charges will no longer be paid at billed rates. Charges for these services will be subject to payment structure which is more in line with Medicare like rates.

KAIROS MEMBER WEBSITE

Check out the new member page on the Kairos website for specific information regarding the Kairos benefits offered by your employer.

SVC.KAIROSHEALTHAZ.ORG

The site includes all sorts of information to help you navigate your benefits, including: benefit details, forms, resource information, and the latest news.

I live for changes like this.

ARE YOU READY FOR THIS?

During the open enrollment period, it's important that you complete the following items:

CHOOSE YOUR PLAN

Select a medical program option and decide who you're going to cover. Your choices for coverage are:

- employee;
- employee plus spouse;
- domestic partner (if permitted by your employer);
- employee plus child(ren); or
- employee plus family.

MAKE A CONTRIBUTION TO YOURSELF

If you enroll in a high deductible health plan (HDHP), determine if you wish to contribute to a health savings account (HSA). Refer to the health savings account section of this guide for more information.

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 or not to elect any voluntary products, and submit required information.

NOTE: Please refer to your benefits department for your open enrollment date.

Do not miss the open enrollment period. It's the one time each year you can make changes (unless you have a qualifying event; see p.7 for more information).

WHO'S ELIGIBLE FOR BENEFITS?

- full-time employees working at least 30 hours per week;
- part-time employees working a minimum of 20 hours per week, if your employer allows part-time coverage;
- active board members or council members, as permitted by their host organizations;
- dependents of enrolled employees, including:
  a. lawfully married spouses;
  b. domestic partners (if allowed by your employer);
  c. dependent children up to age 26; and
  d. unmarried children who are mentally or physically handicapped and fully dependent on the enrolled employee for support and maintenance.

If you have questions about your eligibility, please contact your benefits department or refer to the Plan Document/Benefit Grid located on the Kairos website under the Benefit Information tab.

WHEN CAN YOU MAKE A CHANGE?

Benefit plans are administered on a "policy year basis"—from July 1 through June 30 of the following year. This means that elections you make during annual open enrollment are effective from July 1, 2019 through June 30, 2020.

Because some of the benefits you elect are offered on a pre-tax basis, the Internal Revenue Service (IRS) does not allow changes to these benefit elections outside of the annual open enrollment period, unless you have a qualified mid-year "change in status event." (See p. 7)

Changes must be made within 31 days of the change in status event. If you don't make changes within this timeframe, your next opportunity to make changes to your coverage will be during the subsequent open enrollment period.

WHAT EVENTS QUALIFY?

Some common mid-year change in status events include:

- marriage, divorce, legal separation, or annulment;
- birth, adoption, placement for adoption, or legal guardianship of a child;
- the death of a dependent;
- a change in your spouse's employment, or involuntary loss of health coverage under another employer's plan;
- a loss of coverage under the Medicare or Medicaid programs;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying premiums on a timely basis; and
- cessation of your dependent child's qualification as an eligible dependent.

Note: This list is not inclusive of all mid-year or special enrollment changes. For more information, please visit the Kairos website or contact your benefits department.

HELPFUL TIPS

Losing medical coverage through the Marketplace is not considered a qualified change in status 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.

> Expecting a baby? Congratulations! If you want Kairos coverage for your child, please remember to complete the appropriate documentation within 31 days following the birth. Coverage for newborns is **not automatic**, so you must notify Kairos within this time period and pay the full premium for the month the child is added (if necessary).

31 DAYS

Dependent children up to age 26 may be covered under a parent's plan, regardless of student or marital status.

Participants may not be covered by more than one Kairos employer's plan for any benefits.

YOU HAVE CHOICES!

Kairos offers a flexible benefits program that lets you choose from different medical plan option(s) using the Blue Cross Blue Shield of Arizona (BCBSAZ) network.

COMPARING YOUR OPTIONS

Each plan option offered by your employer covers the same type of services. The plans differ, however, in the costs you could incur during the plan year. Please review the plan summary pages for each option, and contact your benefits department if you have questions or need additional information.

LOOKING FOR ADDITIONAL RESOURCES? WE'VE GOT YOU COVERED.

Benefits 101	Choosing the Right Plan Part 1	Choosing the Right Plan Part 2	Medical Plan Cost Estimator
bit.ly/2VH0Frh	bit.ly/2NKwpJx	bit.ly/2HkGpYL	bit.ly/2UqO5My

Also, as you review the plan information, keep in mind the following key terms:

ANNUAL DEDUCTIBLE	Amount of covered medical expenses you pay each fiscal year (from July 1 to June 30) before the plan pays any benefits.
IN-NETWORK VERSUS OUT-OF-NETWORK SERVICES	You can use any qualified provider you choose. However, in-network providers have agreed to accept specific, contracted fee amounts as payment in full for services rendered. The plan also places a lower limit on your out-of-pocket expenses when you stay within the network. When you use an out-of-network provider, your out-of-pocket costs will likely be considerably higher.
COINSURANCE	A percentage of covered medical costs you pay once you meet the deductible; the plan pays the balance. Example: You might be required to pay 20% for a specific service, while the plan pays 80%. There are different coinsurance requirements for in-network and out-of-network services.
OUT-OF-POCKET MAXIMUM	This is the maximum amount you and your family could be required to pay for services under your plan during the course of a year. Once your deductible plus coinsurance reaches the out-of-pocket maximum for in-network services, the plan pays 100% of your covered costs for the rest of the plan year. There is no out of pocket maximum for out-of-network services.

TIP: To gain the best savings, use in-network providers.
(To find an in-network provider, visit azblue.com and click on Find a Doctor.)

DEDUCTI-WHAT?

As indicated on the previous page, your deductible is the amount of covered medical expenses you pay each fiscal year (from July 1 to June 30) before the plan pays any benefits.

You must meet separate deductibles for in-network and out-of-network services.

If you are on a high deductible health plan (HDHP), you must meet your deductible before the plan will pay prescription benefits. See the prescription section of this guide for more information.

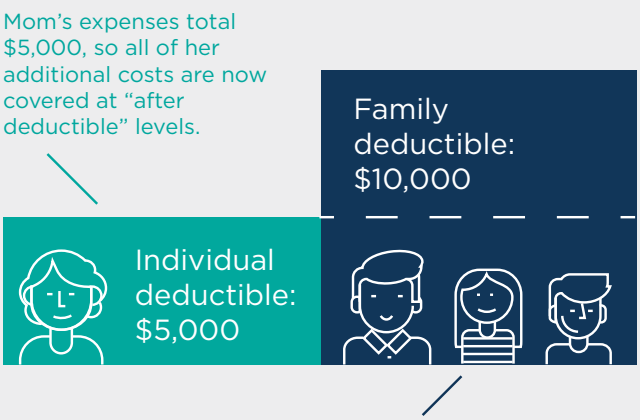
If you are on a family plan, be sure you understand whether your deductible is embedded or non-embedded. This can make a difference in your out-of-pocket costs.

With embedded deductible plans, each family member has an individual deductible. When an individual family member reaches his or her deductible, the plan will begin to pay benefits for that individual, regardless of whether the family deductible has been met. Once the family deductible is met, the plan pays benefits for all.

With non-embedded plans, there are no individual deductibles. The total family deductible must be met before the plan begins to pay benefits for any individual family member.

EXAMPLE: EMBEDDED VS NON-EMBEDDED

EMBEDDED DEDUCTIBLE



The family continues to pay the next $5,000 in expenses for dad and the kids, until the combined family expenses reach the $10,000 family deductible. At that point, additional costs for the whole family are paid at "after deductible" levels.

NON-EMBEDDED DEDUCTIBLE

Family deductible: $10,000

There are no individual deductibles. Instead, family members' expenses are applied solely to the $10,000 family deductible. This deductible must be met before benefits are paid at "after deductible" levels for any member of the family.

Individual deductible: (N/A)

This example does not represent a Kairos medical plan; it is solely an example of how embedded vs. non-embedded deductibles work.

See medical summary for details of your medical plan.

WHAT ABOUT MEDICATIONS?

Your prescription drug benefit can be used to obtain prescriptions from any participating pharmacy listed on the MaxorPlus pharmacy network.

Prescription drug benefits are paid based on a formulary, which is a list of drugs that are covered under the plan.

If you choose an HDHP, you must meet the annual medical plan deductible before your plan will pay a prescription drug benefit, with the exception of certain preventive medications and medical services not subject to the deductible.

The MaxorPlus member portal, located on the MaxorPlus website, allows easy access to:

- locate a network pharmacy near you;
- view the plan formulary;
- find a detailed list of preventive medications and medical services;
- order replacement ID cards;
- sign up for mail order;
- review your prescription history; and
- lots more!

GETTING THE MOST FROM YOUR PRESCRIPTION BENEFIT

The following tips can help reduce the amount of money you pay for prescriptions:

- Consider generic medications; they're a less expensive option than brand name drugs.
- Buy medications through the mail.
- Shop around for your medications.
- Ask your doctor if there is an over-the-counter alternative to your prescription.

For more detailed information, visit the frequently asked questions section of the Kairos website.

AN APPLE A DAY WON'T CUT IT

STAY HEALTHY WITH PREVENTIVE BENEFITS

Some medical plan benefits are considered preventive* and are paid for 100% by the plan—with no deductible—when obtained in-network. (Out-of-network benefits are covered at 50%.) Whether in-network or out-of-network, these services must be coded and billed as preventive by your provider to be paid at the stated rates.

Examples of preventive benefits include:

- Female adult physical exams and annual well woman exams
- Contraceptives (generic) for women
- Screening mammograms (once per year beginning at age 35)
- Prostate screenings like prostate-specific antigen (PSA) blood test
- Adult physical exam, including blood pressure, weight, personal and family history, general physical exam, breast exam, and testicular exam
- Annual screening pap smear and lab work
- Annual flu shot (influenza vaccine) and other CDC-recommended adult immunizations
- Screenings: cholesterol or lipid panel; blood glucose
- Hearing exam (also called an audiometry exam)
- Screening colonoscopy**
- Well child: exam visits; CDC-recommended immunizations; physical exam for sports

**Please see your Blue Cross Blue Shield Benefits Guidebook for a complete list of preventive services.*

***This benefit is covered 100 percent in-network with no deductible once every 10 years starting at age 50. It is not covered out-of-network. It may be payable at a younger age or more frequently—see the Plan Document/Benefit Guide for details.*

SEE A DOCTOR AT YOUR CONVENIENCE

Did you know the average cost for an emergency room visit is $1,800, and the average urgent care visit costs $126? We know you have better things to do with your money and your time! Why not see a doctor, for less, in the convenience of your own home? With BlueCare Anywhere, you can sign in on a computer or mobile device and conduct a live virtual visit with a board-certified medical professional—any day, anytime, anywhere. Simply log in to your BCBSAZ member portal or download BlueCare Anywhere at the App Store® or on Google Play.™

Whether you're at home, work, or even while you're traveling, get fast help and even a prescription, if necessary, for common health issues such as:

- cold, flu, fever;
- cough, bronchitis;
- diarrhea, vomiting;
- headache;
- pinkeye;
- rashes;
- sinus infection;
- sore throat;
- sprains and strains; and
- stomach bugs.

BlueCare Anywhere℠ | BlueCross BlueShield of Arizona

You can also remotely connect with a certified counselor, psychologist, or psychiatrist for help with anxiety, depression, divorce or grief counseling, smoking cessation, stress from parenting or a major life change, weight concerns, and more.

Consultation fees vary for behavioral health visits depending on provider scope and service provided. Please see the BlueCare Anywhere website for additional details.

LIFE CAN BE COMPLICATED

Healthy Blue

HealthyBlue is a set of wellness tools, resources, and services to help you and your family live a healthier, more productive lifestyle. With HealthyBlue, you can measure your progress and get the support you need to stay focused on reaching your health goals. HealthlyBlue programs include :

- **MY BLUEPRINT WELLBEING ASSESSMENT**
  online health assessment
- **VIRTUAL COACHING**
  self-paced online health and behavior change program
- **HEALTHYBLUE ONLINE**
  no-cost online health tools and resources
- **NURSE ON CALL**
  registered nurses available 24/7 to assist with questions
- **BLUE365**
  select savings for products and services to maintain health
- **LIFESTYLE COACHING**
  personalized one-on-one health support
- **CONDITION MANAGEMENT**
  support and resources for chronic conditions
- **CARE MANAGEMENT**
  interactive support for complex or unexpected events

FOR MORE INFORMATION

visit www.azblue.com/healthyblue

or call (877) MY-HBLUE (877-694-2583)

HEALTH CARE PLANS!

BENEFIT OVERVIEW	CORE PLAN	
	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%, no deductible
Well Child Care	Plan pays 100%, no deductible	Plan pays 50%, no deductible
Telehealth	Plan pays 80%, after deductible	N/A
Outpatient Lab and X-ray (including MRI, PET, and CT)	Plan pays 80%, after deductible	Plan pays 50%, after deductible
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 Behavioral Visit	Plan pays 80%, after deductible	Plan pays 50%, after deductible
Retail Prescription Drugs (30-day supply)	You pay: • Generic: $10 • Preferred: 30% (maximum of $35) • Non-Preferred: 50% (maximum of $75) • Specialty: 50% (maximum of $75)	
Mail Order Drugs (90-day supply)	You pay: • Generic: $25 copay • Preferred: $50 copay • Non-Preferred: $90 copay	

This plan has an embedded individual deductible and an embedded out-of-pocket limit. This means that although a deductible and out-of- pocket limit 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 limit. This is true whether or not the family deductible has been met.

(1) 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 limit 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.

BENEFIT OVERVIEW	COPAY PLAN	
	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 +2 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%, no deductible
Well Child Care	Plan pays 100%, no deductible	Plan pays 50%, no deductible
Telehealth	$0 copay	N/A
Outpatient Lab and X-ray (including MRI, PET, and CT)	Plan pays 80%, after deductible	Plan pays 50%, after deductible
Emergency Room	Plan pays 80%, after deductible	Plan pays 80%, after deductible
Urgent Care	$40 copay	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 Behavioral Visit	Plan pays 80%, after deductible	Plan pays 50%, after deductible
Retail Prescription Drugs (30-day supply)	You pay: • Generic: $10 • Preferred: 30% (maximum of $35) • Non-Preferred: 50% (maximum of $75) • Specialty: 50% (maximum of $75)	
Mail Order Drugs (90-day supply)	You pay: • Generic: $25 copay • Preferred: $50 copay • Non-Preferred: $90 copay	

This plan has an embedded individual deductible and an embedded out-of-pocket limit. This means that although a deductible and out-of-pocket limit 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 limit. This is true whether or not the family deductible has been met.

(1) Under the Copay Plan, certain services are covered by a copay; all other benefits 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 limit 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.

BENEFIT OVERVIEW	$1,500 HDHP ($3,000 FAMILY*)	
	IN NETWORK (4)	OUT OF NETWORK (4)
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%, no deductible
Well Child Care	Plan pays 100%, no deductible	Plan pays 50%, no deductible
Telehealth	Plan pays 80%, after deductible	N/A
Outpatient Lab and X-ray (including MRI, PET, and CT)	Plan pays 80%, after deductible	Plan pays 50%, after deductible
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 Behavioral Visit	Plan pays 80%, after deductible	Plan pays 50%, after deductible
Retail Prescription Drugs: After Deductible is Met (30-day supply) (3)	You pay: • Generic: $10 • Preferred: 30% (maximum of $35) • Non-Preferred: 50% (maximum of $75) • Specialty: 50% (maximum of $75)	
Mail Order Drugs: After Deductible is Met (90-day supply) (3)	You pay: • Generic: $25 copay • Preferred: $50 copay • Non-Preferred: $90 copay	

**This plan has a non-embedded deductible. 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 deductible applies toward the annual out-of-pocket maximum on the HDHP plans.

(3) 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: maxorplus.com.

(4) 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.

HSA WHAT? SAVINGS!

HOW THE HSA WORKS

When you elect coverage under one of the high deductible health plans (HDHPs), you have the option of opening a health savings account (HSA).* Your HSA can help pay for eligible health care medical, dental, and vision expenses, along with expenses not covered by the plan, such as your deductible. (HSA-eligible expenses are described in IRS Publication 502, or you can find a list of specific qualified medical expenses on the Health Equity website.)

For 2019/2020, if you are an active employee, you can contribute up to $3,500 for individual coverage and $7,000 for family coverage (less any contributions made by your employer) on a pre-tax basis. If you are 55 or older, you may also make an additional $1,000 "catch-up" contribution.

Tax Deductible

- **Contributions are deductible**
- **Employer can contribute**

Tax-Free Withdrawals

- **For qualified medical expenses—forever!**
- **Dental & vision expenses qualify**

Tax-Deferred Growth

- **Funds grow with no tax liability**
- **After age 65 can be used like a retirement account**

Note: Even if you stop participating in an HDHP, or if you leave your job, you will still be able to use the money in your HSA to pay for qualified expenses. The money is yours to keep.

Learn how to maximize your HSA savings by visiting:

www.healthequity.com/learn/.

QUESTIONS?

Contact HealthEquity:
866-346-5800
www.healthequity.com

EXAMPLE: INDIVIDUAL TAX SAVINGS

For 2019, a single person making $40,000 would reduce their federal and Arizona state taxes by approximately $640 for the year by contributing the maximum of $3,500 into an HSA.

HSA ELIGIBILITY

To be eligible to contribute to the HSA, you must meet the requirements as stated under IRS Publication 969. Some of the common requirements include:

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

For complete rules and requirements, please contact the IRS or visit: www.irs.gov/publications/p969.

**If enrolling in an HSA, you may need to complete additional forms. If applicable, these will be provided during your open enrollment meeting, and should also be available from your benefits department.*

FLEX THOSE DOLLARS!

FLEXIBLE SPENDING ACCOUNTS

The Medical Expense Reimbursement Account and the Dependent Care Account are flexible spending accounts (FSAs) that can save you money on taxes by allowing you to pay for certain expenses with pre-tax dollars.

If you enroll in an HDHP plan and want to contribute to your employer's Medical Expense Reimbursement Account FSA, special rules apply. You may only use your Medical Expense Reimbursement Account to reimburse yourself for eligible dental and vision expenses.

HOW FLEXIBLE SPENDING ACCOUNTS WORK

- The Kairos FSA plans are administered by Basic.
- You decide how much you want to contribute on an annual basis into one or both of the FSAs.
- Your FSA contributions are deducted from your paychecks on a pre-tax basis, in equal amounts each pay period.
- Your election stays in effect for the entire plan year (July 1 through June 30). You may not increase, decrease, or cancel your contributions outside of the plan's enrollment period, unless you have a qualified life status change (see page 7 for information about status changes).
- You use your FSA contributions to pay for eligible expenses under the Medical Expense Reimbursement Account or Dependent Care Account. The IRS clearly defines eligible expenses, and only those that comply with the Internal Revenue Code are eligible for reimbursement.
- You may not use the contributions you make to the Medical Expense Reimbursement Account to reimburse yourself for eligible expenses under the Dependent Care Account, or vice versa.

QUESTIONS?

Contact Basic: 800-372-3539 | www.basiconline.com

USING YOUR MEDICAL REIMBURSEMENT ACCOUNT

In general, you can use the money in a Medical Expense Reimbursement Account to pay for eligible healthcare expenses that are not: (1) covered by your or your spouse's healthcare plans; or (2) used as healthcare deductions on your income tax return. Depending on your employer's plan option, you may contribute between $500 and $2,700 for 2019/2020.

You can use the plan's Flex Convenience debit card to pay most eligible expenses through your Medical Expense Reimbursement Account. Alternatively, you can submit your expenses for reimbursement.

When you use your FSA debit card, you'll be required to substantiate your spending. Documentation must include the following information: provider name, service provided, date of service, and amount charged. Failure to substantiate your purchase within 30 days may result in deactivation of your FSA debit card.

USING YOUR DEPENDENT CARE ACCOUNT

BASIC

The Dependent Care Account lets you set aside pre-tax dollars to help you pay the cost of care for your eligible dependents so that you (and your spouse) can work outside your home. You may contribute between $500 and $5,000 annually. However, your contributions may be limited by your tax-filing status, by your spouse's participation in a similar plan, by a spousal disability or status as a full-time student, or if you use the federal dependent care tax credit. Consult your tax or financial advisor to determine how much to contribute to the Dependent Care Account.

The Dependent Care Account is strictly monitored by the IRS, and only those expenses that comply with the Internal Revenue Code are considered covered expenses. More information is available through the IRS website at: www.irs.gov/pub/irs-pdf/p503.pdf.

FLEXING SPENDING ACCOUNT: USE IT OR LOSE IT

The IRS governs the administration of flexible spending account plans. Once you elect to set aside money in an FSA, you must use it for eligible expenses during the plan year. You should make every effort to file your FSA claims as you incur expenses. However, you have 90 days after the plan year-end (June 30) to file claims for reimbursement. After that point, you forfeit, or lose, any unused funds. Because of this IRS "use it or lose it" rule, you should carefully estimate the amount you want to contribute to your FSA(s) before making your elections.

EAP PREFERRED | An IBH Company

The Kairos Employee Assistance Program (EAP) offers 24-hour telephone 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;
- alcohol and substance abuse;
- personal, emotional, and work-related difficulties;
- child and day care resources;
- financial information and resources;
- legal information and resources;
- will preparation services; and
- elder care (most services).

Coverage includes up to six one-on-one counseling sessions (per family member, per issue, per year) at no cost to you. If applicable, for first responders, 12 one-on-one counseling sessions are included for a traumatic on-the-job event.

TO SPEAK TO A PROFESSIONAL ADVISOR, CALL 1-800-327-3517
OR VISIT THE EAP WEBSITE USING THE USERNAME & PASSWORD BELOW:

Website: www.eappreferred.com
Username: **kairos**
Password: **eappreferred**

DELTA DENTAL®

QUESTIONS?
Contact Delta Dental: 602-938-3131 | 800-352-6132
www.deltadentalaz.com

Delta's dental plan allows you and your eligible dependents to visit any dentist or specialist without a referral. The plan also travels with you anywhere in the country. All you have to do is log on to the Delta Dental website—www.deltadentalaz.com to find an in-network provider, or call 1-800-352-6132.

You must meet the plan year deductible before benefit coverage applies. The deductible is waived for preventive services. However, these services apply toward your annual maximum benefit (see the table below).

You can save money on out-of-pocket costs and maximize your annual benefit by making sure to choose a PPO provider. Remember to always verify that your dentist is a PPO provider when making an appointment.

VOLUNTARY DENTAL PLAN—SELECT PLAN

BENEFIT COVERAGE	PPO DENTIST	PREMIER AND OUT-OF-NETWORK DENTIST(1)
Annual Maximum Benefit (2)	$1,500	$1,500
Annual Deductible (individual/family) (2)	$50/$150	$50/$150
Lifetime Orthodontia Maximum (2)	Child $1,500	Child $1,500
Preventive Services (twice a year) Exams Routine cleanings Fluoride: for children up to age 18 Sealants: for children up to age 19 X-rays Space maintainers: for children up to age 14	100%	100%
Basic Services Fillings Crowns Emergency treatment Endodontics: root canal treatment Periodontics: treatment of gum disease Oral surgery: simple extractions Oral surgery: surgical extractions	80% (3)	80% (3)
Major Services Prosthodontics: bridges, partial dentures, complete dentures (once every 5 years) Bridge and denture repair implants (once every 5 years) Restorative: crowns and onlays (once every 5 years)	50% (3)	50% (3)
Orthodontic Services Benefit for children ages 8–19. Children must be banded prior to age 17 (annual maximum separate for orthodontia).	50% (3)	50% (3)

(1) Members may incur higher out-of-pocket costs when seeing a Premier or out-of-network dentist.
(2) Combination of in-network and out-of-network.
(3) Deductible applies to these services.

TDA
Total Dental Administrators

QUESTIONS?
Contact TDADental: 888-422-1995
www.TDADental.com

SUMMIT CARE PLUS DHMO—TOTAL CARE PLAN

Total Dental Administrators (TDA) is a comprehensive, predetermined–service fee dental plan that has contracted with private practice dentists to provide convenient, affordable, quality dental care. There are no deductibles, no claim forms, and no annual or lifetime benefit maximums. The plan provides preventive care and includes orthodontics for children and adults. It also covers eligible dependents up to age 26. Services are covered only in the state of Arizona.

Prior to making an appointment, you must select the general dental office for yourself and your dependents by accessing the TDA website, selecting the DHMO dental plan network, and entering your search criteria. Each participating dental facility has a Dental Office Code number listed to the right of the dental office. Be sure to use this code number to identify your selection when enrolling for benefits or calling customer service (1-888-422-1995).

See below for a brief summary of benefits. For a more detailed list of services, please visit the TDA website.

TDA COVERAGE	TDA ADVANTAGES
Diagnostic care	No deductibles
Preventive care	No claim forms
Restorative care	No annual or lifetime benefit maximums
Endodontics	No industry exclusions
Periodontics	Coverage for pre-existing conditions
Prosthodontics	Coverage for orthodontics
Oral surgery	Local service
TMJ	
Orthodontics	

PLEASE CONTACT TDA CUSTOMER SERVICE AT 1-888-422-1995
IF YOU WOULD LIKE TO CHANGE YOUR PROVIDER MID-YEAR.

TDAonline gives you more freedom and ability to:

- Verify your personal information in the TDA system
- Verify and update your address
- Print out copies of your EOBs
- Search past claims
- Review you annual benefit maximum

QUESTIONS?
Contact VSP: 800-877-7195
www.vsp.com

VOLUNTARY VISION

Using your VSP Choice benefit is easy. Simply create an account at www.vsp.com. Once your plan is effective, you can review your benefit information and find an eye doctor who's right for you. At your appointment, tell the office staff that you have VSP. There's no ID card necessary. If you'd like a card for reference, you can print one at vsp.com.

You may visit any vision care provider, but know that benefits are provided at significantly higher levels when you visit an in-network doctor. For assistance, visit the VSP website (www.vsp.com) or call 800.877.7195.

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your coverage with a VSP Choice provider			
Well Vision Exam	Focuses on your eyes and overall wellness	$10	Every 12 months
Prescription Glasses		$25	See Frames & Lenses
Frame	$150 allowance for a wide selection of frames $170 allowance for featured frame brands 20% savings on the amount over your allowance $85 Costco and Walmart frame allowance	Included in prescription glasses copay	Every 12 months
Lenses	Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children	Included in prescription glasses copay	Every 12 months
Lens Enhancements	Standard progressive lenses Premium progressive lenses Custom progressive lenses Ultraviolet lenses Average savings of 20–25% on other lens enhancements	Covered $95–$105 $150–$175 Covered	Every 12 months
Contacts (instead of glasses)	$150 allowance for contacts; the copay (fitting and evaluation exam) does not apply toward the cost of contact lens	Up to $60	Every 12 months

MetLife

QUESTIONS?
Contact Metlife: 800-638-5433
www.metlife.com

BASIC LIFE INSURANCE

Your employer provides eligible employees with basic life insurance coverage in the amount of $50,000 in the event of death. In the event of an accidental death or dismemberment, there is an additional benefit of up to $50,000. 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.

Additionally, MetLife provides extended support services such as travel assistance, estate resolution, and grief counseling. Please contact MetLife or your Kairos representative for more information.

You must designate a beneficiary at least 18 years of age for the basic life insurance benefit. To update your beneficiary information, please contact your benefits department.

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 dependent coverage. Note: The amount of coverage, once elected, will not automatically reduce with age. However, your premium will increase as you age.

THE POOL OFFERS THE FOLLOWING 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 off age of employee.	
Child	$1,000 (0–14 days)	
Child	$2,000–$10,000 (15 days up to age 26) in $2,000 increments	
CHILD RATE PER $1,000	$0.162	
AGE BANDS AND RATES PER $1,000	< age 30	$0.071
	30–34	$0.091
	35–39	$0.101
	40–44	$0.111
	45–49	$0.161
	50–54	$0.241
	55–59	$0.441
	60–64	$0.671
	65–69	$1.281
	70 +	$2.655

MetLife

QUESTIONS?
Contact Metlife: 800-638-5433
www.metlife.com

SHORT-TERM DISABILITY INSURANCE

Eligible employees can elect to purchase voluntary short-term disability coverage through MetLife. This benefit replaces a portion of your pre-disability earnings, less any income that was actually paid to you during the same disability from other sources. Disability insurance helps provide income protection for employees with unexpected health events, associated expenses, and possible time away from work due to a non-occupational injury or sickness.

The monthly disability benefit may not exceed 60% of your salary, up to a $1,000 weekly maximum.

Benefits begin following the plan's 14-day elimination period, and are paid for up to 11 weeks of continuous disability. This plan includes maternity as part of the covered benefits and typically pays 6 weeks for a normal pregnancy.

PRE-EXISTING CONDITION LIMITATIONS

The policy does not cover an illness or accidental injury that arose in the three months prior to your plan effective date. In addition, to be eligible for coverage during pregnancy, your pregnancy must occur on or after the benefit effective date (e.g., July 1, 2019 if you are enrolling during open enrollment).

IMPORTANT:

If you receive a salary increase, your short-term disability does not increase automatically.

You may sign up for this coverage only during open enrollment, or as a new hire.

You may not drop coverage until the next open enrollment period.

MetLife

QUESTIONS?
Contact Metlife: 800-638-5433
www.metlife.com

HOSPITAL INDEMNITY

The hospital indemnity plan offers a cash benefit when an employee requires hospitalization and is 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.

BENEFIT TYPE	MetLife Hospital Indemnity Insurance Pays YOU
Hospital Coverage (Sickness)	
Admission ***Payable once per calendar year***	$500 (non-ICU) $500 (ICU)
Confinement ***Paid per sickness***	$200 a day (non-ICU) for up to 15 days $200 a day (ICU) for up to 15 days
Other Benefits	
Health screening (wellness) benefit provided if the covered insured takes one of the covered screening/prevention tests ***Payable once per calendar year***	$50

HOW IT WORKS

On his way to work, Bill's car is hit by a large truck on the highway. Due to the severity of the impact, the car is totaled and Bill is injured. When police and medics arrive at the scene of the accident, they call for an ambulance. 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 spending two days in the Intensive Care Unit, he is moved to a standard room and stays there for five more days. Bill is then transferred for in-patient care at a rehabilitation facility. His stay there is seven days. Bill would receive a lump-sum payment totaling $4,200.

COVERED EVENT[1]	BENEFIT AMOUNT
Hospital Admission	$500
ICU Supplemental Admission	$500
Hospital Confinement for 5 Days	$1,000 ($200 per day)
In-Patient Rehab Unit	$1,400
ICU Confinement for 2 days	$800 ($400 per day)

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

MetLife

QUESTIONS?
Contact Metlife: 800-638-5433
www.metlife.com

CRITICAL ILLNESS

Critical illness insurance can provide financial protection to help lessen the burden of large out-of-pocket costs for employees who suffer a critical illness.

CRITICAL ILLNESS INSURANCE		
Eligible Individual	Initial Benefit	Requirements
Employee	$10,000, $20,000, or $30,000	Coverage is guaranteed, provided you are actively at work.*
Spouse/Domestic Partner	50% of the employee's initial benefit	Coverage is guaranteed, provided the employee is actively at work and the spouse/ domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.
Dependent Child(ren)	50% of the employee's initial benefit	Coverage is guaranteed, provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.

*Coverage is guaranteed subject to terms and exclusions.

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).

MetLife

QUESTIONS?
Contact Metlife: 800-638-5433
www.metlife.com

ACCIDENT INSURANCE

Accident insurance 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.

BENEFIT TYPE	Plan Pays
Injuries	
Fractures and Dislocations	$100–$6,000
Second & Third Degree Burns	$100–$10,000
Concussion	$400
Cuts/Lacerations	$50–$400
Eye Injuries	$300
Medical Services & Treatment	
Ambulance	$300–$1,000
Emergency Care	$50–$100
Non-Emergency Care	$50
Physician Follow-Up	$75
Therapy Services (including physical therapy)	$25
Medical Testing Benefit	$200
Medical Appliances	$100–$1,000
Inpatient Surgery	$200–$2,000
Hospital Coverage (Accident)	
Admission	$1,000 (non-ICU)–$2,000 (ICU) per accident
Confinement	$200 a day (non-ICU)—up to 31 days $400 a day (ICU)—up to 31 days
Inpatient Rehab	$200 a day, up to 15 days per accident, but not to exceed 30 days per calendar year

MetLife

QUESTIONS?
Contact Metlife: 800-638-5433
www.metlife.com

ACCIDENT INSURANCE CONTINUED

BENEFIT TYPE	Plan Pays
Accidental Death	
Employee receives 100% of amount shown, spouse receives 50%, and children receive 20%.	$50,000 $150,000 for common carrier
Dismemberment, Loss & Paralysis	
$500—$50,000 per injury	
Other benefits	
Lodging: Pays for lodging for companion up to 30 nights per calendar year Health screening benefit (wellness): Benefit provided if the covered insured takes one of the covered screening/ prevention tests	$200 per night, up to 30 nights; up to $6,000 in total lodging benefits available per calendar year $50 Payable once per calendar year

HOW ACCIDENT INSURANCE 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 emergency room 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 get 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.*

THIS OPEN ENROLLMENT 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 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.

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);
- 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 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.

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 the 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 get another copy of this notice from Kairos.

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.

REQUIREMENT TO PROVIDE THE TAXPAYER IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN) OF EACH HEALTH PLAN ENROLLEE

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) for each medical plan participant and include that number on reports that are provided to the IRS each year. If you have a covered dependent who does not yet have a social security number, you can go to this website to request one: http://www.socialsecurity. gov/online/ss-5.pdf. Applying for a social security number is FREE.

If you have not yet provided the social security number (or other TIN) for each dependent enrolled in the health plan, please contact Kairos at 888-331-0222

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.

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).

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 Care Marketplace. (See https://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 for 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 Basic at 877-262-7202.

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 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.

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 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your state for more information on eligibility.

ALABAMA-MEDICAID	ALASKA-MEDICAID
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS-MEDICAID	FLORIDA-MEDICAID
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268

GEORGIA-MEDICAID	INDIANA-MEDICAID
Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA-MEDICAID	KANSAS-MEDICAID
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY-MEDICAID	LOUISIANA-MEDICAID
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447

MAINE-MEDICAID	MASSACHUSETTS-MEDICAID & CHIP
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840

MINNESOTA-MEDICAID	MISSOURI-MEDICAID
Website: https://mn.gov/dhs/people-we-serve/seniors/healthcare/health-care-programs/programs-andservices/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: https://www.dss.mo.gov/mhd/participants/pages/hipp. htm Phone: 573-751-2005

MONTANA-MEDICAID	NEBRASKA-MEDICAID
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HI PP Phone: 1-800-694-3084	Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178

NEVADA-MEDICAID	NEW HAMPSHIRE-MEDICAID
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218

NEW JERSEY-MEDICAID & CHIP	NEW YORK-MEDICAID
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA-MEDICAID	NORTH DAKOTA-MEDICAID
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA-MEDICAID & CHIP	OREGON-MEDICAID
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

PENNSYLVANIA-MEDICAID	RHODE ISLAND-MEDICAID
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

SOUTH CAROLINA-MEDICAID	SOUTH DAKOTA-MEDICAID
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS-MEDICAID	**UTAH-MEDICAID & CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT-MEDICAID	**VIRGINIA-MEDICAID & CHIP**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm. Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance. CHIP Phone: 1-855-242-8282
WASHINGTON-MEDICAID	**WEST VIRGINIA-MEDICAID**
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN-MEDICAID & CHIP	**WYOMING-MEDICAID**
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565