KAIROS
HEALTH ARIZONA, INC.

2023–2024 BENEFITS

HIGLEY UNIFIED SCHOOL DISTRICT NO. 60

BEFORE WE BEGIN

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HOW TO USE THIS GUIDE

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

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

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

ENROLLMENT CHECKLIST

- **CHOOSE YOUR PLAN**
  Select a medical program option and decide who you're going to cover.
- **MAKE A CONTRIBUTION TO YOURSELF**
  If you have the option to enroll in a high deductible health plan (HDHP), don't miss out on making health savings account (HSA) contributions.
- **TAKE CARE OF YOUR LOVED ONES**
  Review and update beneficiary designations for life insurance benefits as needed.
- **ARE YOUR DEPENDENTS STILL ELIGIBLE?**
  Confirm that any dependents up to age 26 are still eligible to be enrolled.
- **CHOOSE YOUR OTHER COVERAGES**
  If applicable, review and decide whether to elect any additional employee-paid benefits.

GOT QUESTIONS?

KAIROS
General plan questions, claims questions, and ID cards
888.331.0222
svc.kairoshealthaz.org

UMR
Medical benefits, eligibility, and ID cards
844.212.6811
umr.com

COMPSYCH
EAP counseling services
833.955.3386
guidanceresources.com

MAXORPLUS
Prescription benefits
800.687.0707
maxorplus.com

WHAT'S NEW?

LISTEN UP!

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

NEW FOR 2023–2024

1. The $1,400 HDHP will become a $1,500 HDHP, or $3,000 family deductible.
2. Teladoc coverage is available with no cost-share on all medical plans, including HDHPs, until new federal regulations tell us otherwise.
3. We continue to expand our one-of-a-kind clinical advocacy program! We now have a dedicated mental health nurse to assist you with your mental health and wellbeing needs.
4. Fees for Active&Fit gym memberships will increase from $25 to $28/month beginning April 1, 2023.
5. There are some great enhancements to supplemental life and worksite products. -Please refer to the appropriate benefit pages.

PLAN RULES

WHO'S ELIGIBLE?

Eligibility varies, but here are some general eligibility categories:

- ✓ Full-time employees working at least 30 hours per week
- ✓ Part-time employees working at least 20 hours per week (ancillary coverage only)
- ✓ Dependents of enrolled employees, including:
  - — lawfully married spouses
  - — domestic partners (domestic partner's children are not eligible)
  - — dependent children up to age 26
  - — unmarried children who are mentally or physically handicapped and fully dependent on the enrolled employee for support and maintenance

WHEN CAN I MAKE A CHANGE?

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

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

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

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

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

WHAT DOES IT ALL MEAN?

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

DEDUCTIBLE

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

COINSURANCE

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

OUT-OF-POCKET MAXIMUM (OOP)

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

EMBEDDED DEDUCTIBLE

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

NON-EMBEDDED DEDUCTIBLE

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

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) VS. PPO PLAN

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

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

IN-NETWORK VS. OUT-OF-NETWORK

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

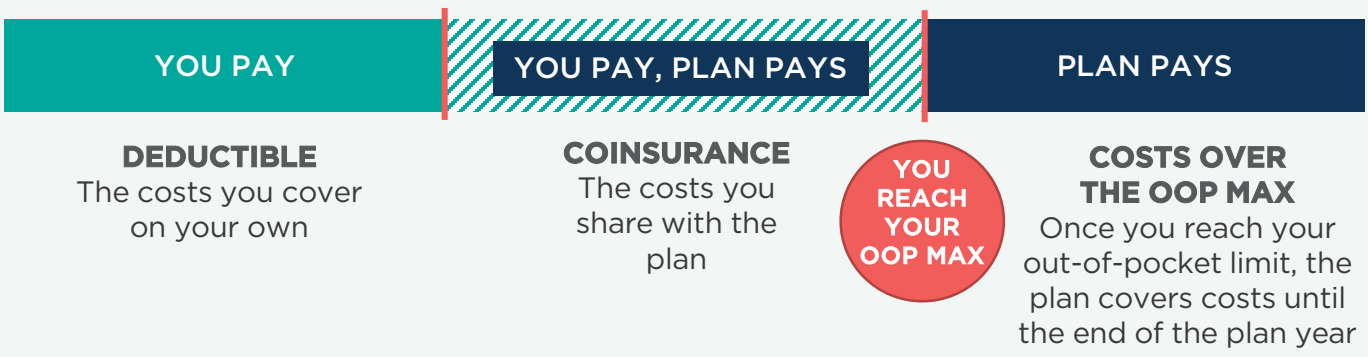
INPATIENT VS. OUTPATIENT

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

PRIOR AUTHORIZATION

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

How does my medical plan work?



MEDICAL BENEFITS

UMR/UNITEDHEALTHCARE

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

Where does Kairos fit in?

KAIROS
The Plan

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

UnitedHealthcare
Medical Network

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

UMR
Claims Handling

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

MANAGE YOUR BENEFITS

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

Once you're in, you can:

- ✓ View/print/order ID card(s)
- ✓ View medical claims
- ✓ Monitor deductible and out-of-pocket limits
- ✓ Shop for the best and most cost-efficient care

FIND A DOCTOR

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

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

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

PRESCRIPTION BENEFITS

MAXORPLUS

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

Sign up for the MaxorPlus member portal to:

Locate the closest and most cost-efficient network pharmacy

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

Look up your prescription history and plan costs

TIPS FOR SAVING ON PRESCRIPTIONS

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

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

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

✓ **USE MAIL ORDER**
Mail order delivers medications to your doorstep for less than it costs to go to your local pharmacy. For example, if a prescription costs $180 for a three-month supply at retail, it could cost $150 through mail order. It's like getting half a month for free!

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

CLINICAL ADVOCACY: EXPERTS ON *YOUR* SIDE

CLINICAL ADVOCACY PROGRAM

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

With this program, you have:

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

Examples of how our clinical advocacy nurses help:

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

Real Story from a Real Kairos Member

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

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

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

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

The Positive Outcome for Sidney

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

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

Give us a call to learn more.

WELLBEING

WHAT'S "WELLNESS" ALL ABOUT?

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

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

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

PREVENTION IS PRICELESS

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

Examples of preventive benefits include:

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

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

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

MORE BENEFITS

TELADOC

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

You'll get fast and 24/7 help for non-emergency matters like:

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

BONUS!
Mental health benefits: Talk to a therapist or psychiatrist by appointment via phone or video for things like anxiety, depression, stress, and more.

Dermatology benefits: Diagnose and treat skin conditions via the mobile app for things like eczema, rashes, and more.

For questions, contact Teladoc at 800.835.2362 or visit teladoc.com.

COMPSYCH EAP

With ComPsych, you have 6 one-on-one counseling sessions per family member, per issue, per year at no cost to you.

Professional advisors are available 24/7 to help you and your family with:

- ✓ Stress and anxiety
- ✓ Relationship matters
- ✓ Substance abuse
- ✓ Minor depression management

BONUS!
Online resources: Visit the website below to access family resources, legal and financial consultations, on-demand trainings, discounts, and more!

For questions, contact ComPsych at 833.955.3386 or visit guidanceresources.com.
Web ID: KairosEAP

AND NOW... THE MEDICAL PLANS!

CHOICE $0 PPO
BENEFIT OVERVIEW

	IN-NETWORK[4]	OUT-OF-NETWORK[4]
DEDUCTIBLE[1]	$0/employee $0/family	$900/employee $2,700/family
OUT-OF-POCKET MAXIMUM[2]	$6,350/employee $12,700/family	$30,000/employee $60,000/family
OFFICE VISITS	$30 copay primary care physician $40 copay specialist	Deductible, then 50%
URGENT CARE	$50 copay	Deductible, then 50%
EMERGENCY ROOM	$150 copay	$150 copay
WELLNESS SERVICES (ADULT/CHILD)	No deductible, $0	Deductible, then 50%
TELEHEALTH (TELADOC)[3]	No deductible, $0	Not available
OUTPATIENT SURGERY	$75 per service	Deductible, then 50%
INPATIENT SERVICES	$250 copay per admission	Deductible, then 50%
IMAGING (CT/PET scans, MRIs)	$30 copay	Deductible, then 50%
HOME HEALTH CARE	No deductible, $0	Deductible, then 50%
SKILLED NURSING CARE	$250 copay per admission	Deductible, then 50%
REHABILITATION SERVICES	$30 copay	Deductible, then 50%

PRESCRIPTIONS

RETAIL (Up to 31-day supply)	• Generic: $15 • Preferred: $30 • Non-preferred: $50 • Specialty: Not applicable
MAIL ORDER (Up to 90-day supply)	• Generic: $37.50 • Preferred: $75 • Non-preferred: $125

[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. All benefits are subject to the deductible, unless otherwise noted. The medical plan deductible does not apply to retail and mail order prescription drug copays.

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

[3]Teladoc services are covered at 100%, subject to the expiration of the CARES Act. Once the CARES Act expires, services will revert to the pre-CARES cost structure, with applicable copays/deductibles.

[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.

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

CHOICE $500 PPO
BENEFIT OVERVIEW

	IN-NETWORK[4]	OUT-OF-NETWORK[4]
DEDUCTIBLE[1]	$500/employee $1,000/family	$1,200/employee $2,400/family
OUT-OF-POCKET MAXIMUM[2]	$4,500/employee $9,000/family	$30,000/employee $60,000/family
OFFICE VISITS	$30 copay primary care physician $40 copay specialist	Deductible, then 50%
URGENT CARE	$50 copay	Deductible, then 50%
EMERGENCY ROOM	Deductible, then 20%	Deductible, then 20%
WELLNESS SERVICES (ADULT/CHILD)	No deductible, $0	Deductible, then 50%
TELEHEALTH (TELADOC)[3]	No deductible, $0	Not available
OUTPATIENT SURGERY	Deductible, then 20%	Deductible, then 50%
INPATIENT SERVICES	$250 copay per admission	Deductible, then 50%
IMAGING (CT/PET scans, MRIs)	No deductible, 20%	Deductible, then 50%
HOME HEALTH CARE	Deductible, then 20%	Deductible, then 50%
SKILLED NURSING CARE	Deductible, then 20%	Deductible, then 50%
REHABILITATION SERVICES	$30 copay	Deductible, then 50%

PRESCRIPTIONS

RETAIL (Up to 31-day supply)	• Generic: $15 • Preferred: $30 • Non-preferred: $50 • Specialty: Not applicable
MAIL ORDER (Up to 90-day supply)	• Generic: $37.50 • Preferred: $75 • Non-preferred: $125

[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. All benefits are subject to the deductible, unless otherwise noted. The medical plan deductible does not apply to retail and mail order prescription drug copays.

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

[3]Teladoc services are covered at 100%, subject to the expiration of the CARES Act. Once the CARES Act expires, services will revert to the pre-CARES cost structure, with applicable copays/deductibles.

[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.

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

CHOICE HDHP $1500 BENEFIT OVERVIEW	IN-NETWORK[4]	OUT-OF-NETWORK[4]
DEDUCTIBLE[1]	$1,500/employee $3,000/family	$2,500/employee $5,000/family
OUT-OF-POCKET MAXIMUM[2]	$6,000/employee $6,850/family	$18,000/employee $28,000/family
OFFICE VISITS	Deductible, then 20%	Deductible, then 50%
URGENT CARE	Deductible, then 20%	Deductible, then 50%
EMERGENCY ROOM	Deductible, then 20%	Deductible, then 20%
WELLNESS SERVICES (ADULT/CHILD)	No deductible, $0	Deductible, then 50%
TELEHEALTH (TELADOC)[3]	No deductible, $0	Not available
OUTPATIENT SURGERY	Deductible, then 20%	Deductible, then 50%
INPATIENT SERVICES	Deductible, then 20%	Deductible, then 50%
IMAGING (CT/PET scans, MRIs)	Deductible, then 20%	Deductible, then 50%
HOME HEALTH CARE	Deductible, then 20%	Deductible, then 50%
SKILLED NURSING CARE	Deductible, then 20%	Deductible, then 50%
REHABILITATION SERVICES	Deductible, then 20%	Deductible, then 50%

PRESCRIPTIONS

RETAIL (Up to 31-day supply)	• Generic: $10 • Preferred: $35 • Non-preferred: $60 • Specialty: Not applicable
MAIL ORDER (Up to 90-day supply)	• Generic: $25 • Preferred: $87.50 • Non-preferred: $150

[1]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 preventive/wellness care). It also means that the out-of-pocket maximum applies to the family as a whole rather than to individual covered family members. All benefits are subject to the deductible, unless noted otherwise. The medical plan deductible does not apply to retail and mail order prescription drug copays.

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

[3]Teladoc services are covered at 100%, subject to the expiration of the CARES Act. Once the CARES Act expires, services will revert to the pre-CARES cost structure, with applicable copays/deductibles.

[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.

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

CHOICE $5,000 PPO BENEFIT OVERVIEW	IN-NETWORK[4]	OUT-OF-NETWORK[4]
DEDUCTIBLE[1]	$5,000/employee $10,000/family	$15,000/employee $30,000/family
OUT-OF-POCKET MAXIMUM[2]	$6,250/employee $12,500/family	$45,000/employee $90,000/family
OFFICE VISITS	$30 copay primary care physician $60 copay specialist	Deductible, then 50%
URGENT CARE	$100 copay	Deductible, then 50%
EMERGENCY ROOM	$300 copay	$300 copay
WELLNESS SERVICES (ADULT/CHILD)	No deductible, $0	Deductible, then 50%
TELEHEALTH (TELADOC)[3]	No deductible, $0	Not available
OUTPATIENT SURGERY	Deductible, then 30%	Deductible, then 50%
INPATIENT SERVICES	Deductible, then 30%	Deductible, then 50%
IMAGING (CT/PET scans, MRIs)	$300 copay	Deductible, then 50%
HOME HEALTH CARE	Deductible, then 30%	Deductible, then 50%
SKILLED NURSING CARE	Deductible, then 30%	Deductible, then 50%
REHABILITATION SERVICES	$30 copay	Deductible, then 50%
PRESCRIPTIONS		
RETAIL (Up to 31-day supply)	• Generic: $15 • Preferred: $30 • Non-preferred: $50 • Specialty: Not applicable	
MAIL ORDER (Up to 90-day supply)	• Generic: $37.50 • Preferred: $75 • Non-preferred: $125	

[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. All benefits are subject to the deductible, unless otherwise noted. The medical plan deductible does not apply to retail and mail order prescription drug copays.

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

[3]Teladoc services are covered at 100%, subject to the expiration of the CARES Act. Once the CARES Act expires, services will revert to the pre-CARES cost structure, with applicable copays/deductibles.

[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.

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

MORE BENEFITS WITH YOUR BENEFITS

HEALTH SAVINGS ACCOUNT (HSA)

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

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

HSA Advantages

Triple Tax Benefit

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

It's Yours Forever

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

Grow and Save

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

YOU'RE ELIGIBLE FOR AN HSA IF:

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

HOW MUCH CAN YOU CONTRIBUTE?

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

Learn how to maximize your HSA

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

FLEXIBLE SPENDING ACCOUNT (FSA)

Set aside pre-tax dollars for eligible health care and dependent care expenses in a flexible spending account (FSA) administered by HealthEquity. These accounts are also referred to as consumer-driven accounts, or CDAs. You elect how much you want to contribute in equal installments throughout the year.

	MEDICAL REIMBURSEMENT FSA*	DEPENDENT CARE FSA*
WHAT ARE THE ANNUAL CONTRIBUTION LIMITS?	Up to $3,050 (depending on your employer's plan option)	Up to $5,000 or $2,500 if married filing separately (tax filing status and participation in other plans may affect contribution limits)
WHAT CAN AN FSA BE USED FOR?	Eligible medical, dental, and vision expenses that are not already covered or deducted on your income taxes	Eligible childcare expenses
HOW ARE REIMBURSEMENTS MADE?	Claim form submitted via employee portal, fax, or mail	Claim form submitted via employee portal, fax, or mail

ANYTHING ELSE I NEED TO KNOW ABOUT FSAs?

Use it or Lose it—Any money set aside in the FSA must be used for eligible expenses during the plan year. Claims for reimbursement can be submitted up to 90 days after the plan year ends on June 30. After that, funds are forfeited.

Plan Carefully—Your election stays in effect for the entire plan year (July 1 through June 30). Once you make your election, you can only change your contribution amount if you experience a qualified status change (see page 4 for information about status changes).

Keep it Compliant—The IRS clearly defines eligible expenses, and only those that comply with the Internal Revenue Code are eligible for reimbursement. In all cases, itemized documentation for transactions should be retained.

How your FSA works

1

VISIT PROVIDER
Visit your medical/dental/vision/Rx provider and give them your insurance information.

2

PROVIDER BILLS
Your provider will send the claim to your insurance or may bill you directly.

3

PAY YOUR PROVIDER
Use your HealthEquity Visa Healthcare Card to pay your provider, or pay online through the HealthEquity member portal.

DELTA DENTAL INSURANCE

Kairos's dental plan through Delta Dental 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. Delta Dental issues ID cards to new enrollees. If you ever need a replacement, please contact Kairos or Delta Dental.

While both PPO and Premier dentists are in-network, you will save more money when using a PPO dentist. Out-of-pocket costs increase by going out-of-network.

SELECT PLAN BENEFIT OVERVIEW	PPO AND PREMIER DENTIST	OUT-OF-NETWORK DENTIST
ANNUAL MAXIMUM BENEFIT[1]	$1,500	$1,500
ANNUAL DEDUCTIBLE (EMPLOYEE/FAMILY)[1]	$50/$150	$50/$150
LIFETIME ORTHODONTIA MAXIMUM[1]	Child $1,500	Child $1,500
PREVENTIVE SERVICES (TWICE A YEAR)[2] Exams Routine cleanings Fluoride: For children up to age 18 Sealants: For children up to age 19 X-rays Space maintainers	$0	$0
BASIC SERVICES Fillings Stainless steel crowns Emergency treatment Endodontics: Root canal treatment Periodontics: Gum disease treatment Oral surgery: Simple and surgical extractions	Deductible, then 20%	Deductible, then 20%
MAJOR SERVICES[3] Prosthodontics: Bridges, partial dentures, complete dentures Bridge and denture repair Implants Restorative: Crowns and onlays	Deductible, then 50%	Deductible, then 50%
ORTHODONTIC SERVICES[4] Benefit for children ages 8–19. Children must be banded prior to age 17.	50%	50%

[1]Combination of in-network and out-of-network.
[2]Preventive services are deducted from the annual maximum benefit.
[3]Major services may be subject to a 5 waiting period from the date services were last performed. Refer to the plan certificate for more information.
[4]Orthodontia has a separate annual maximum.

TDA DENTAL INSURANCE

Total Dental Administrators (TDA) provides comprehensive dental care on a predetermined fee schedule. There are no deductibles, no claim forms, and no annual or lifetime benefit maximums. Services are covered in the state of Arizona only.

NO ID CARD NECESSARY. TDA will issue an ID card to new enrollees. You don't need your card, though, to receive dental care—your dentist will have your name on file once covered.

DHMO PLAN
BENEFIT OVERVIEW

	IN-NETWORK COPAY
PREVENTIVE/DIAGNOSTIC	
Initial exam	$0
Adult cleaning	$0
Office visits	$0
RESTORATIVE	
Amalgam (one surface)	$13
Amalgam (two surfaces)	$24
Resin (one surface)	$29
Resin (two surfaces)	$40
CROWN & BRIDGE	
Crown porcelain	$495*
Crown buildup	$80
ENDODONTICS	
Root canal therapy (anterior)	$195
Root canal therapy (molar)	$399
ORAL SURGERY	
Simple extraction	$40
Soft tissue impaction	$90
PROSTHETICS	
Complete denture	$615*
Partial denture	$550*
PERIODONTICS	
Osseous surgery/quad	$390

**Copay includes lab fee. Lab fees may vary; check with your provider for more details.*
Refer to plan summary for a complete list of covered services.

HOW TO USE YOUR PLAN

STEP 1: Access the TDA website prior to making an appointment. Select the general dental office for yourself and your dependents.

STEP 2: Select the DHMO dental plan network and enter your search criteria.

STEP 3: Make note of the provider code number listed to the right of the dental office. You'll use this code number to identify your selection when enrolling for benefits or calling customer service.

Contact TDA customer service at the number below if you need to change your provider mid-year.

VSP VISION INSURANCE

Using your VSP Choice benefit is easy. Simply create an account at VSP.com. Once your account is activated, you can review your benefit information and find an eye doctor who's right for you.

NO ID CARD NECESSARY. At your appointment, tell the office staff that you have VSP. They may ask for additional personal information to verify your coverage. From there, you're good to go. You can also print out an ID card for reference through your online VSP account.

CHOICE PLAN BENEFIT OVERVIEW	IN-NETWORK COPAY	FREQUENCY
VISION EXAM	$10	Every 12 months
PRESCRIPTION GLASSES	$25	See Frames & Lenses
FRAMES $200 featured frame brands allowance $180 frame allowance 20% savings on your allowance $100 Walmart/Sam's Club/Costco frame allowance	Included in prescription glasses copay	Every 12 months
LENSES Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for children	Included in prescription glasses copay	Every 12 months
LENS ENHANCEMENTS Standard progressive lenses UV protection Premium progressive lenses Custom progressive lenses Average savings of 30% on other lens enhancements	$0 $0 $95–$105 $150–$175	Every 12 months
CONTACTS (INSTEAD OF GLASSES) $150 allowance; no copay Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
ESSENTIAL EYECARE PROGRAM Retinal screening for members with diabetes Additional exams and services for members with diabetic eye disease, glaucoma, or age-related macular degeneration. Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 $20 per exam	As needed

ENJOY SHOPPING ONLINE?

Go to eyeconic.com and use your vision benefits to shop over 50 brands of contacts, eyeglasses, and sunglasses. Brands include Bebe, Calvin Klein, Gucci, Ray-Ban, Nike, Nine West, and more!

BASIC LIFE AND AD&D INSURANCE

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

The original amount reduces to $22,500 at age 70, $15,000 at age 75 and $10,000 at age 80.

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

SUPPLEMENTAL LIFE AND AD&D INSURANCE

You have the opportunity to purchase additional life insurance coverage for yourself, your eligible spouse, and your dependent children. You are responsible for paying the cost of this benefit, as stated in the plan summary. Unlike basic life insurance, your supplemental life insurance amount will not reduce with age. However, the amount you pay out of pocket will increase as you age.

NEW FOR 2023–2024: Existing employees may now elect or increase their supplemental life up to the guaranteed issue amount without completing EOI (see definitions below). This only applies to employee coverage, a new election or increase for spouse coverage would still require EOI. Employees can elect coverage for their dependents without having to elect coverage for themselves.

SUPPLEMENTAL COVERAGE AMOUNTS

	YOU	YOUR SPOUSE	YOUR CHILDREN
AVAILABLE AMOUNTS	$10,000–$500,000 in increments of $10,000 Cannot exceed 5 times your annual salary	$5,000–$250,000 in increments of $5,000 Cannot exceed 100% of your supplemental life benefit	Up to 15 days old: $1,000 15 days to 26 years: choice of $10,000, $15,000 or $20,000
GUARANTEED ISSUE AMOUNT	$250,000	$50,000	$10,000

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

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

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

SHORT-TERM DISABILITY

You can elect to purchase 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 from other sources for the same disability. Disability insurance helps provide income protection for those 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 66 2/3% of your salary, up to a $1,500 weekly maximum.

Benefits begin following the plan's 7-day elimination period and are paid for up to 26 weeks of continuous disability. This plan includes maternity as part of the coverage, and typically pays six weeks of benefits 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, 2023 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.

WORKSITE BENEFITS

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

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

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

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

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

HEALTH SCREENING BENEFITS AVAILABLE

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

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

When you're ready to claim your $50:

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

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

The guide attempts to describe important details and changes to the 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 and Higley retain 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": Choice $0; Choice $500; $1,500 HDHP; and Navigate Plus.

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

PRIVACY NOTICE REMINDER

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

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

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

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

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

MID-YEAR CHANGES TO YOUR HEALTH CARE BENEFIT ELECTIONS

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

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

- 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 the Higley Benefits Department at 480.279.7013.

Mid-year change-in-status event: Because Higley 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 Benefits Department within 31 days of the mid-year change-in-status event by contacting the Higley Benefits Department at 480.279.7013. The Benefits Department 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 health care provider; however, payment by the plan may be less for the use of a non-network provider.

You also do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including, obtaining prior authorization for certain services; following a pre-approved treatment plan; or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kairos at 888.331.0222.

COBRA COVERAGE REMINDER

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

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

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

In addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. You may wish to seek coverage through the Health Insurance Marketplace. (See www.healthcare.gov.) In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible—such as a spouse's plan—if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

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

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

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

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

If you or your children are eligible for Medicaid or CHIP, and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage using funds from the Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP, and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial 877.KIDSNOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 1, 2022. Contact your state for more information on eligibility.

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid

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: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

CALIFORNIA – Medicaid

Website:
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program
(HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711

Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

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

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

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

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