KAIROS
HEALTH ARIZONA, INC.

2025–2026 BENEFITS GUIDE

AMPHITHEATER
Public Schools

MEET KAIROS

Hey! We're Kairos, your benefits plan administrator. Throughout this guide, you'll find great information on the benefits offered by your employer. When in doubt, give Kairos a call if you have questions about any of these benefits. **We're your friendly experts, here to help you!**

PLAN YEAR

The Kairos plan runs from July 1 to June 30 of each year. That means every July 1, deductibles and out-of-pocket maximums will reset.

WHAT'S NEW?

There are some enhancements this year, called out in the appropriate section in the guide. Just look for anything labeled "new!".

ABOUT THIS GUIDE

This interactive guide provides a summary of benefit options to help you make the right decisions for yourself and your family. If there is a conflict between this guide and the wording of plan documents, the plan documents will govern. A copy of the plan document is distributed annually or available upon request.

HOW TO USE

It's simple to use; just follow these instructions.

Looking for something? To navigate through the eGuide, simply click through the pages using the arrows. Prefer to skip to a certain section? Just click on the **Table of Contents** or **Pages** icons to jump to the section you need.
You will also see a **Search** bar. When you're looking for something, simply type the word in the search bar, and it will direct you to that section.

Clickable links. When you see an icon like the ones listed below, just click on it to access more information such as:

View websites, member portals, and documents

Watch a short, educational video

Listen to a voiceover about the information on the applicable page (click to start or stop the voiceover)

Send an email and get in contact with someone

IMPORTANT!

Please note that the voiceover feature in this guide will only work if you use the electronic link provided. If you download the eGuide as a PDF, the voiceover will not work. Also, not every page will offer a voiceover option. To get a link to your eGuide, please contact Kairos or your employer.

WHO'S ELIGIBLE?

Eligibility varies, but here are some general eligibility categories:

- ✓ Full-time employees .75 or above, working 30 hours a week;
- ✓ Dependents of enrolled employees, including:
  - — lawfully married spouse
  - — 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

Please contact your Benefits Department if you have questions about eligibility.

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 to your benefits.

Examples of qualified life events:

- 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

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

HAD A BABY?

If you recently had a baby, please note that 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 do not take action within 31 days of the birth, you will have to wait until next open enrollment period to add your child to your benefits.

ELIGIBLE FOR MARKETPLACE COVERAGE?

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

STARTING WITH THE BASICS

We get it, insurance is complicated. It doesn't have to be. Kairos strives to simplify this for you by providing educational information, short videos, and spending the time to walk you through it.

So, let's start with the basics like what a deductible is and how it works. Check out this short video that explains the different terminology of how a medical plan works.

Medical Benefits 101
Click the link or scan the code to watch this quick video

HOW A MEDICAL PLAN WORKS

Let's walk through an example together using a $1,650 high deductible health plan with a $4,500 out-of-pocket maximum.

YOU PAY	BOTH PAY	KAIROS PAYS
DEDUCTIBLE $1,650 You're responsible for paying 100% of costs	**COINSURANCE 20%** After your deductible, you pay 20% of expenses & Kairos pays 80%	**OUT-OF-POCKET $4,500** After your maximum, Kairos pays 100% of all expenses

Note: This is a general overview of how a medical plan works. Actual amounts may vary based on the plans offered by your employer. Always remember to stay in-network to maximize your benefits. Refer to the medical plan section for more details about plans offered to you.

PREVENTION IS PRICELESS

There are services under a medical plan that are 100% paid for when visiting an in-network provider. These are called your preventive services, or wellness care, and are set by the Affordable Care Act (ACA).

Examples of preventive benefits include:

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

But what happens if I receive a bill from my provider for a qualified wellness screening?

This could mean that you had a diagnostic screening or it may have been coded incorrectly. Get in touch with Kairos at the number below and we can help you through it.

UMR

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

NOTE: Since our high deductible health plans have changed, UMR will be issuing new ID cards to participants enrolling in the HDHP for 7/1. Be on the lookout for your new cards.

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 medical network you have, you'll say, "United" or "UnitedHealthcare Choice Plus"

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).

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.

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 to register. From there, you can:

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

did you know?

Not all doctors and facilities charge the same amount for services.

Individuals who compare costs before receiving care pay 36% less.

You shop for car insurance, so why not shop for your medical care?

When logged into the UMR portal, leverage their Cost Transparency Tool to get cost estimates for services.

PHARMACY BENEFITS

MAXORPLUS

When you enroll in our medical plan, you automatically receive prescription drug coverage through MaxorPlus, the Pharmacy Benefit Manager (PBM). This benefit allows you to fill prescriptions through any participating pharmacy listed in the MaxorPlus pharmacy network.

MANAGE YOUR BENEFITS

Your pharmacy coverage includes access to a member portal at members.maxorplus.com. At a glance, you can use the member portal to:

- ✓ View your prior authorization activity
- ✓ Manage pharmacy refills
- ✓ View deductible and out-of-pocket limits
- ✓ Sign up for home delivery
- ✓ Shop around for pharmacies and medications

TIPS

- If you're on a high deductible health plan, **you must pay for the full cost of medications prior to meeting your deductible** unless it's considered a covered and qualified preventive medication.
- Thanks to the ever-changing market, covered medications change often throughout the year. If you're ever concerned about a medication being covered, contact Maxor at the number below or Kairos (888.331.0222).
- If you like convenience, sign up for mail order to have your 90-day medications delivered right to your doorstep. This might not be an option for everyone but is a great benefit for those who qualify.

SHOPPING FOR 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 that they're significantly cheaper. Talk to your prescriber to see if generics are right for you.

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 benefits, and other important health updates. Call 888.596.0723 to enroll or go to mymaxorlink.com/maxorplus.

TRY GOODRx

GoodRx could be a good option for those expensive medications or medications not covered by insurance. Please note, however, that when using GoodRx, your insurance will not apply.

NURSES ON YOUR SIDE

KAIROSPRO NAVIGATORS

Navigating health care and insurance can be complicated and leave you feeling overwhelmed. That's where we come in. Through the **KairosPro Navigators** program, our dedicated Kairos 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 real person in your corner who not only has a clinical background but understands your insurance coverage and is there to provide support **at no cost to you.**

How can our nurses help you?

- ✓ Finding in-network providers
- ✓ Assisting with appeals and prior authorizations
- ✓ Reviewing and monitoring claims
- ✓ Obtaining medical and prescription orders
- ✓ Monitoring high-cost medications and medical treatment
- ✓ Coordinating medical services, prescriptions, and durable medical equipment supplies
- ✓ Monitoring inpatient admissions
- ✓ Helping with post-discharge needs
- ✓ Overseeing and collaborating with partner case management programs
- ✓ Arranging for redirection of care, if appropriate
- ✓ Attending onsite biometric screening events and engaging in outreach and follow-up
- ✓ Researching and connecting members with community resources

Bonus: This program offers personalized mental health support for finding in-network mental health providers, lining up post-discharge resources, and more!

Want to speak to a Nurse Navigator? Call 888.331.0222 or send an email to nurse@kairoshealthaz.org
(Please include the name of your employer and refrain from emailing sensitive and personal information.)

SKIP THE ER & USE TELADOC

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

TELADOC

COVERED SERVICES

- **General medicine:** Treat cold & flu, allergies, strep throat, and more
- **Dermatology:** Treat psoriasis, eczema, acne, and more (no phone call needed)
- **Counseling:** Support for anxiety, eating disorders, depression, and more

NEW: Starting July 1, 2025, Teladoc will now collect a fee for services for those on a high-deductible health plan until they meet their deductible. However, these fees can be significantly lower than if you were to go to Urgent Care or the Emergency Room, for example $54 for a visit.

WAIT! DID YOU REGISTER?

You must create an account through Teladoc before you can access your benefits. Click the link, scan the code, or call Teladoc at 800.835.2362.

Please note: Enrolled dependents ages 18+ must set up their own Teladoc account prior to receiving care.

WELLNESS PROGRAMS

Our wellness programs—available through **KairosPro Wellness**—include a variety of options to help promote a healthier and happier you. Take advantage of these offerings at no cost (unless you see a cost listed).

KAIROSPRO WELLNESS

UMR CARE programs

Maternity care program: Whether you are considering having a baby or are already expecting, UMR Maternity CARE can explain how to reduce your risk of complications and prepare you to have a successful, full-term pregnancy and a healthy baby. When completing the program, you'll receive a $25 incentive!

Ongoing condition care program: For those who need help when managing chronic conditions like diabetes, COPD, asthma, hypertension, and more, this program is for you.

Complex condition care program: Get assistance with complex cases such as transplants, oncology, high-risk maternity, and neonatal care.

Real Appeal weight loss program

A no-cost healthy lifestyle and weight loss program for employees and dependents 18+. Participants on the medical plan who qualify based on BMI or comorbidities can work directly with a health coach.

Sign up at enroll.realappeal.com.

UMR online wellness center

Our online wellness hub provides wellness activities to keep you on track for healthy eating, weight management, physical activity, and more.

Log in at umr.com, click on Health Center, and then Wellness Activity Center to use these benefits.

Employee Network discount tool

Through EmployeeNetwork.com, you can register to receive over 300 exclusive discounts. These include tickets to theme parks, concerts, sporting events, and more.

Use **Company Code: Kairos Health** when registering. (Yes, there should be a space between Kairos and Health.)

Active&Fit Direct fitness program

Starting at $28/month, you'll get access to 18,000+ fitness centers with no long-term contracts. With your membership, you also get online workout videos, one-on-one life coaching, and options for enrolling your spouse.

For more information on how to access this benefit, please visit kairoshealthaz.org/AFD.

KAIROS VITALITY VIBE

Vitality Vibe is your monthly newsletter dedicated to promoting healthy habits and recipes, wellness offerings, and other valuable benefit insights.

These are emailed out to you from your employer on a monthly basis. They are also posted on the Kairos website underneath **Resources**: www.svc.kairoshealthaz.org.

Vitality Vibe Newsletters
Scan the code to access

COMPSYCH EAP

Everyone can use a little help sometimes. That's where your EAP benefit comes in. Through the employee assistance program (EAP) with ComPsych, you can speak with a highly-trained and compassionate guidance consultant who can help you and your family 24/7.

FREE SHORT-TERM COUNSELING

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

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

WORK-LIFE SOLUTIONS

Get the everyday help you need with work-life solutions. Call the number at the bottom of the page for assistance with topics including:

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

ONLINE RESOURCES

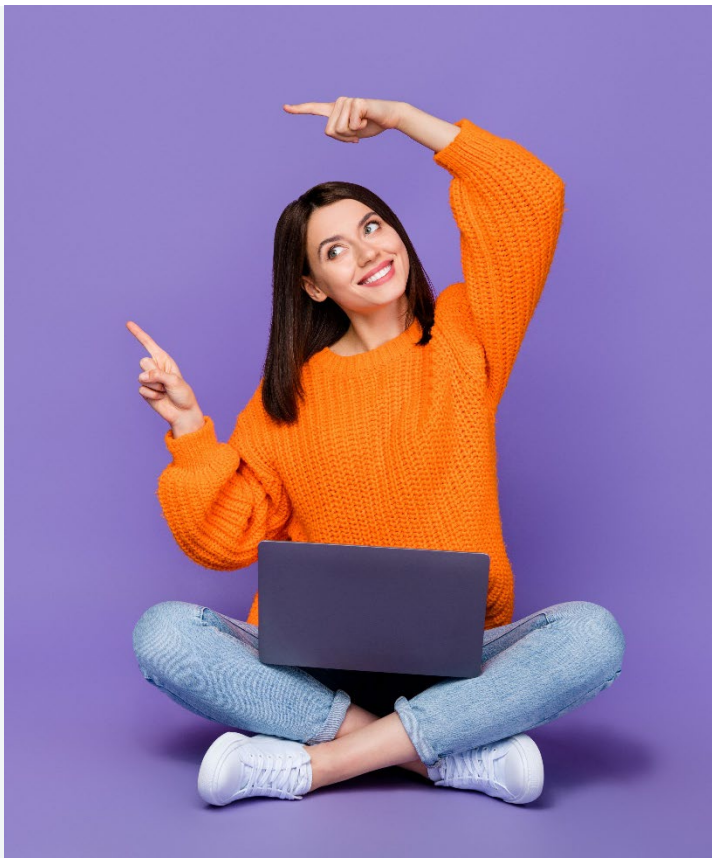
You have 24/7 access to vital information, tools, and support through the ComPsych website.

WHAT TO EXPECT

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

HOW TO ACCESS

1. Go to guidanceresources.com
2. Click Register
3. Enter Web ID: **KAIROSEAP**
4. Complete your registration
5. Gain access to endless resources



OPTIONS, OPTIONS, OPTIONS

Kairos offers an abundance of health care options for you to choose from. At times, this could feel overwhelming. Don't let it be. Save this guide to help you when deciding where to go.

TELADOC	URGENT CARE	PRIMARY CARE OR SPECIALIST	EMERGENCY ROOM
$	$$	$$	$$$$
• Sore throat • Mild cold and flu symptoms • Skin conditions • Short-term counseling	• Allergic reaction • Cuts requiring stitches • Minor burns • Sprains or strains • Suspected broken bones	• Check ups or physicals • Wellness/preventive care • Common illness • Flu shots and other vaccines • Health advice • Medication refills • Routine tests	• Broken bones • Coughing/vomiting blood • Chest pain • Head or eye injury • Poisoning or overdose • Severe burns • Signs of stroke • Shortness of breath
To get in touch with Teladoc, visit www.teladochealth.com	To find in-network facilities, visit www.umr.com	To find in-network providers, visit www.umr.com	To find in-network facilities, visit www.umr.com

These examples are general guidelines, and it's important to use your judgment and consult with health care professionals when deciding where to seek care. If in doubt, especially in potentially life-threatening situations, it's always best to err on the side of caution and seek emergency care.

CENTERS OF EXCELLENCE

carrumhealth

Do you have an upcoming non-emergent surgery planned? Find care with fewer headaches at our Centers of Excellence facilities, in partnership with Carrum Health. This benefit is available to those enrolled in a medical plan, ages 18 to 65.

COVERED PROCEDURES

- Joint replacement: Hip, knee, ankle, shoulder—total or partial replacement revisions
- Spine (neck and back): Fusion, decompression, laminectomy
- Heart (valve repair)
- Cancer care: Breast, thyroid
- **NEW:** Substance use therapy

BENEFITS

- ✓ Most procedures covered from pre-op consult to post-op discharge
- ✓ Pay no- or low-cost for covered procedures
- ✓ Receive care from proven quality specialists throughout the country
- ✓ Transportation is covered!

Ready to get started? Visit www.carrum.me/kairos or call 888.855.7806.

GOLD PLAN

BENEFIT OVERVIEW	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE	$600/employee $1,200/family	$3,000/employee $9,000/family
OUT-OF-POCKET MAXIMUM	$4,000/employee $8,000/family	Not applicable
OFFICE VISITS	$28 copay primary care physician $36 copay specialist	Deductible, then 50%
TELADOC	No deductible, $0	Not available
URGENT CARE	$46 copay	Deductible, then 50%
EMERGENCY ROOM	Deductible, then 25%	Deductible, then 25%
WELLNESS SERVICES Mammograms Colonoscopies Immunizations Well visits (adult/child)	No deductible, $0	Not applicable
OUTPATIENT SURGERY INPATIENT SERVICES IMAGING (CT/PET scans, MRIs)	Deductible, then 25%	Deductible, then 50%
HOME HEALTH CARE	No deductible, $0	Deductible, then 50%
SKILLED NURSING CARE REHABILITATION SERVICES	$200 copay per admission, then 25%	$300 copay per admission, then 50%
CENTERS OF EXCELLENCE Joint replacement Spine (neck and back) Heart (valve repair) Cancer care: Breast, thyroid Substance use therapy	No deductible, $0	Not available

PRESCRIPTIONS

RETAIL (Up to 31-day supply)	• Generic: $15 • Preferred: 20% ($25 minimum, $80 maximum) • Non-preferred: 40% ($40 minimum, $110 maximum) • Specialty*: 20% copay ($100 minimum, $150 maximum)
MAIL ORDER (Up to 90-day supply)	• Generic: $30 • Preferred: 20% ($50 minimum, $175 maximum) • Non-preferred: 40% ($80 minimum, $225 maximum) • Specialty: Not applicable

**Specialty medications must be filled at a MaxorPlus Specialty Pharmacy and may require a prior authorization. Please reach out to Kairos for assistance with your specialty medications.*

Please note: Information provided above may be subject to change at any time. Please refer to the medical plan document and summary of benefits and coverage for plan exclusions, limitations, and more information.

SILVER PLAN

BENEFIT OVERVIEW	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE	$800/employee $1,600/family	$5,000/employee $15,000/family
OUT-OF-POCKET MAXIMUM	$4,800/employee $9,600/family	Not applicable
OFFICE VISITS	$32 copay primary care physician $40 copay specialist	Deductible, then 50%
TELADOC	No deductible, $0	Not available
URGENT CARE	$50 copay	Deductible, then 50%
EMERGENCY ROOM	Deductible, then 25%	Deductible, then 25%
WELLNESS SERVICES Mammograms Colonoscopies Immunizations Well visits (adult/child)	No deductible, $0	Not applicable
OUTPATIENT SURGERY INPATIENT SERVICES IMAGING (CT/PET scans, MRIs)	Deductible, then 25%	Deductible, then 50%
HOME HEALTH CARE	No deductible, $0	Deductible, then 50%
SKILLED NURSING CARE REHABILITATION SERVICES	$200 copay per admission, then 25%	$300 copay per admission, then 50%
CENTERS OF EXCELLENCE Joint replacement Spine (neck and back) Heart (valve repair) Cancer care: Breast, thyroid Substance use therapy	No deductible, $0	Not available

PRESCRIPTIONS

RETAIL (Up to 31-day supply)	• Generic: $15 • Preferred: 20% ($25 minimum, $80 maximum) • Non-preferred: 40% ($40 minimum, $110 maximum) • Specialty*: 20% copay ($100 minimum, $150 maximum)
MAIL ORDER (Up to 90-day supply)	• Generic: $30 • Preferred: 20% ($50 minimum, $175 maximum) • Non-preferred: 40% ($80 minimum, $225 maximum) • Specialty: Not applicable

**Specialty medications must be filled at a MaxorPlus Specialty Pharmacy and may require a prior authorization. Please reach out to Kairos for assistance with your specialty medications.*

Please note: Information provided above may be subject to change at any time. Please refer to the medical plan document and summary of benefits and coverage for plan exclusions, limitations, and more information.

HIGH DEDUCTIBLE HEALTH PLAN

BENEFIT OVERVIEW	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE	$1,650/employee $3,300/family	$2,500/employee $5,000/family
OUT-OF-POCKET MAXIMUM	$4,500/employee $9,000/family	Not applicable
OFFICE VISITS	$20 copay primary care physician $30 copay specialist	Deductible, then 50%
TELADOC NEW: Fees associated due to legislative changes	Deductible, then $0	Not available
URGENT CARE	$40 copay	Deductible, then 50%
EMERGENCY ROOM	Deductible, then 20%	Deductible, then 20%
WELLNESS SERVICES Mammograms Colonoscopies Immunizations Well visits (adult/child)	No deductible, $0	Not applicable
OUTPATIENT SURGERY INPATIENT SERVICES IMAGING (CT/PET scans, MRIs)	Deductible, then 20%	Deductible, then 50%
HOME HEALTH CARE	Deductible, then 20%	Deductible, then 50%
SKILLED NURSING CARE REHABILITATION SERVICES	Deductible, then $200 copay per admission, then 20%	Deductible, then $300 copay per admission, then 50%
CENTERS OF EXCELLENCE Joint replacement Spine (neck and back) Heart (valve repair) Cancer care: Breast, thyroid Substance use therapy	No deductible, $0	Not available

PRESCRIPTIONS

Your deductible must first be met before copays apply with the exception of preventive medications

RETAIL (Up to 31-day supply)	• Generic: $15 • Preferred: 20% ($25 minimum, $80 maximum) • Non-preferred: 40% ($40 minimum, $110 maximum) • Specialty*: 20% copay ($100 minimum, $150 maximum)
MAIL ORDER (Up to 90-day supply)	• Generic: $30 • Preferred: 20% ($50 minimum, $175 maximum) • Non-preferred: 40% ($80 minimum, $225 maximum) • Specialty: Not applicable

**Specialty medications must be filled at a MaxorPlus Specialty Pharmacy and may require a prior authorization. Please reach out to Kairos for assistance with your specialty medications.*

Please note: Information provided above may be subject to change at any time. Please refer to the medical plan document and summary of benefits and coverage for plan exclusions, limitations, and more information.

HEALTH SAVINGS ACCOUNT (HSA)

If you enroll in a high deductible health plan (HDHP), you will receive 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, screenings, and more! For a complete list, visit healthequity.com/kairos/qme.

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

HSA Advantages

Triple Tax Benefit

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

It's Yours Forever

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

Grow and Save

You can invest the funds, and your earnings grow tax-free. After age 65, you can use the HSA like a traditional retirement account and funds used for non-medical expenses will be taxed as income.

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	$4,300
FAMILY	$8,550
AGE 55+	Additional $1,000

Learn how to maximize your HSA Click link or scan for a short video

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 verifying eligibility and calculating your contributions (including any employer contributions) so that they don't exceed the maximum annual amount.

Please note: If you leave the District, you may keep your HSA however, you will no longer receive employer contributions and are responsible for paying the monthly service fees.

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.

HealthEquity

	MEDICAL REIMBURSEMENT FSA	LIMITED PURPOSE FSA	DEPENDENT CARE FSA
WHAT ARE THE ANNUAL CONTRIBUTION LIMITS?	Up to $3,300 (depending on your employer's plan option)	Up to $3,300 (depending on your employer's plan option)	Up to $5,000 (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 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	Claim form submitted via employee portal, fax, or mail

Please note that not all FSA accounts may be available, depending on what your employer offers. Contact your employer with any questions.

NOTE: If you're enrolled in an HDHP with an HSA, you may only contribute to a limited purpose FSA which is used for eligible dental and vision expenses. You will also receive only one debit card to be used for your HSA and FSA funds.

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 incurred prior to June 30 can be reimbursed up to 90 days after the plan year ends. 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.

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

The PPO 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.

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

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

SELECT PLAN OVERVIEW	PPO, PREMIER, OR NON-PARTICIPATING DENTIST
ANNUAL DEDUCTIBLE[1]	$50/individual $150/family
ANNUAL MAXIMUM BENEFIT[1]	$1,500/individual
PREVENTIVE & DIAGNOSTIC SERVICES (TWICE A YEAR)[2] Exams, fluoride, and cleanings X-rays Sealants: For children up to age 18 Space maintainers Periodontal maintenance	No deductible, $0
BASIC SERVICES Fillings Emergency palliative treatment Endodontics: Root canal treatment Periodontics: Gum disease treatment Oral surgery: Simple and surgical extractions	Deductible, then 20%
MAJOR SERVICES[3] Crown repair Prosthodontics: Bridges, implants, dentures Bridge and denture repair	Deductible, then 50%
CHILD ORTHODONTIA Braces: For children ages 8–19. (Children must be banded prior to age 17) There is a separate $1,500/person lifetime maximum for orthodontic services	Deductible, then 50%

[1]Your annual maximum benefit is a combination for in-network and out-of-network services.
[2]Preventive services are charged against the annual maximum benefit.
[3]Major services have a five-year waiting period.

THIRD CLEANING BENEFIT

Delta Dental offers a third cleaning benefit for those with certain medical conditions that have oral health implications. Research shows that increased frequency of cleanings can greatly impact oral health and play an important role in managing conditions like diabetes, heart disease, pregnancy, cancer and more.

Qualified members must enroll for the enhanced preventive benefits to receive coverage for a third dental cleaning. Contact Delta Dental at 800.352.6132 to enroll.

TDA PREPAID DENTAL INSURANCE

Total Dental Administrators (TDA) an EMI Health Company 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. It's important to stay in-network to get the most of your benefits.**

DHMO PLAN 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

The above table is just an example of covered services. For a complete list, click the icon to refer to the schedule of benefits.

**Copay includes lab fee. Lab fees may vary; check with your provider for more details.*

HOW TO USE YOUR PLAN

STEP 1: Access the TDA website prior to making an appointment to access current providers. 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 to select your dental provider in the portal.

STEP 4: After your effective date, you can schedule an appointment directly with your provider.

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. Once enrolled, create an account at VSP.com where 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 OVERVIEW	IN-NETWORK COPAY	FREQUENCY
WELL VISION EXAM	$10	Every 12 months
ESSENTIAL MEDICAL EYE CARE Retinal imaging for members with diabetes Additional exams to treat pink eye to sudden changes in vision	$20/exam	As needed
PRESCRIPTION GLASSES	$25	See Frames & Lenses
FRAMES $200 featured frame brands allowance $180 frame allowance 20% savings on amount over your allowance $100 Walmart/Sam's Club 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	$0 $0 $95–$105 $150–$175	Every 12 months
CONTACTS (INSTEAD OF GLASSES) $150 allowance; copay does not apply Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months

MEMBER-EXCLUSIVE DISCOUNTS

Eyeconic: Save up to $220 on prescription glasses, sunglasses, and contacts with VSP's online eyewear store. Browse the store here, eyeconic.com.

Member Extras: Want access to over $3,000 in savings? Visit vsp.com/offers for discounted offers on LASIK, contacts, hearing aids, and more!

LIFE INSURANCE

BASIC LIFE AND AD&D INSURANCE

Your employer provides eligible employees with basic life and AD&D. This benefit is at no cost to you in the amount of $25,000, and enrollment is automatic. The amount reduces to 70% at age 70.

VOLUNTARY 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.

	YOU	YOUR SPOUSE	YOUR CHILDREN
AVAILABLE AMOUNTS	$10,000–$750,000 in increments of $10,000 Cannot exceed 5 times your annual salary	$10,000–$250,000 in increments of $5,000 Cannot exceed the combined amount of your basic life and supplemental life benefits	$10,000; $15,000; or $20,000
GUARANTEED ISSUE AMOUNT	$250,000	$50,000	None

IMPORTANT: Evidence of insurability is required for all elections above the guaranteed amounts unless you are a new hire. Please refer to the plan summary for more information.

BENEFICIARY TIPS!

A beneficiary must be selected during enrollment. If no beneficiary is designated, the policy designates an order of payment: spouse first, children, parents, siblings, then insured estate.

Multiple beneficiaries and contingents can be listed. However, the categories taken together should total 100%.

CHOOSING A BENEFICIARY

- ✓ **Can I name a child as a beneficiary?** Yes! However, benefits cannot be paid to a minor. Benefits would be paid to a court-appointed guardian or trust set up for the minor.
- ✓ **How about a pet?** Interesting question and unfortunately, no. Pets aren't legal people, and benefits cannot be paid to them.
- ✓ **Can I choose a charity, non-profit, or school?** Yes. We will need the applicable Tax ID number.
- ✓ **Can I choose a funeral home or trust?** Absolutely.

SHORT-TERM DISABILITY

Short-term disability coverage is employer-paid for full-time employees working at .75 FTE or above. 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 60% of your salary, up to a $1,500 weekly maximum.

Enrollment in this coverage is automatic.

Once you are approved for coverage, you will be eligible to collect your employer-paid short-term disability insurance benefit starting on the 45th day after your injury or 45th day of sickness. Your benefit could continue for up to 20 weeks.

IMPORTANT!

Your benefit payments will be reduced by other income you receive or are eligible to receive due to your disability, such as:

- Social Security Disability Insurance
- Workers' Compensation
- Other employer-based insurance coverage you may have
- Unemployment benefits
- Settlements or judgments for income loss
- Retirement benefits that your employer fully or partially pays for (such as a pension plan)

NATIONWIDE PET

NEW: Fetch the best health coverage for your dog or cat through your voluntary benefits package. Nationwide will offer enhanced plans including two ready-made plans, plus the ability customize a plan based on your needs.

THE PERKS

- ✓ Visit any vet, anywhere
- ✓ Plans are exclusive for Kairos participants
- ✓ Submit a claim from any device
- ✓ Get reimbursed for eligible expenses

MY PET PROTECTION CHOICE	ACCIDENT & ILLNESS	ACCIDENT, ILLNESS, & WELLNESS	CUSTOMIZABLE
Annual deductible options	$250	$250	$100 to $500
Reimbursement level	80%	80%	50, 70, or 80%
ACCIDENT			
Annual maximum	$5,000	$5,000	$2,500 or $5,000
Broken bones, animal attack, hit by care, poisoning, heatstroke, and more	✓	✓	✓
ILLNESS			
Annual maximum	$5,000	$5,000	$2,500 or $5,000
Ear infections, diabetes, vomiting, allergies, cancer, and more	✓	✓	✓
HEREDETARY & CONGENITAL			
Annual maximum	$5,000	$5,000	$2,500 or $5,000
Hip dysplasia, cherry eye, elbow dysplasia, umbilical hernia, and more	✓	✓	✓
WELLNESS			
Annual maximum		$450	$450 or $800
Vaccination or titer, fecal test, microchip, heartworm prevention, and more		✓	✓
Spay/neuter or dental and one additional test			✓

IMPORTANT:

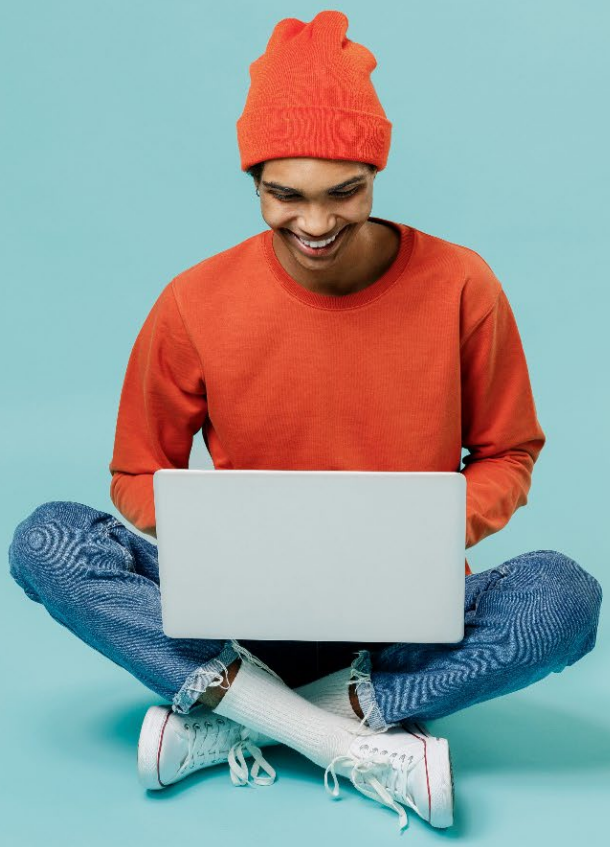
This benefit is not deducted from your paycheck.
You will be responsible for paying the monthly premium directly to Nationwide.

When ready to enroll, sign up at the link below.

Questions: 888.331.0222 or www.svc.kairoshealthaz.org

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

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



Disclaimer: It is the responsibility of the employer to ensure that all required notices are provided to employees and their covered dependents in a timely and accurate manner. Failure to provide these notices can result in significant penalties and legal consequences.

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 your employer. 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 medical coverage to join a Marketplace plan mid-year. You will be required to provide proof of coverage within 31 days of your enrollment.

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.

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. A copy of this notice is posted on the Kairos website at www.svc.kairoshealthaz.org.

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

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

You also do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional who specializes in obstetrics or gynecology. The healthcare 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 healthcare 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: 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 your employer.

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.

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 Kairos is 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": Silver, Gold, an 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.

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).

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

(see next page)

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE, cont.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the COBRA Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both),
- Dependent child ceasing to be a dependent.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must notify WEX Health, Inc. at (866) 451-3399.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE, cont.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period* to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after your group health plan coverage based on current employment ends.

*For more information on the 8-month special enrollment period visit:
www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
For more information visit www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

To obtain more information about the Plan and COBRA continuation coverage upon request, contact Kairos at 888.331.0222.

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 31, 2024. Contact your state for more information on eligibility.

To see if any other states have added a premium assistance program since July 31, 2024, contact U.S. Department of Labor at 866.444.3272 or US Department of Health and Human Services at 877.267.2323.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: www.in.gov/medicaid/ www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: www.insureoklahoma.org Phone: 1-888-365-3742	Website: healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: www.scdhhs.gov Phone: 1-888-549-0820	Website: dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: dhhr.wv.gov/bms/ mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269