

KAIROS
HEALTH ARIZONA, INC.

2022-2023 *BENEFITS*

BEAVER CREEK ESD NO. 26



BEFORE WE BEGIN

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HOW TO USE THIS GUIDE






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

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



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

ENROLLMENT CHECKLIST

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

GOT QUESTIONS?

KAIROS

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

COMPSYCH

EAP counseling services
833.955.3386
guidanceresources.com

UMR

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

MAXORPLUS

Prescription benefits
800.687.0707
maxorplus.com

WHAT'S NEW?

LISTEN UP!

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



1. We're now covering hearing aids under the medical plan! Coverage includes one hearing aid up to \$3,000, per impaired ear, every 3 years.
2. Hang onto your ID cards because they're still good to use! New ID cards will be issued only to new hires and those who are making plan changes.
3. We've made improvements to our PPO plan offerings. If applicable, refer to the medical plan pages (beginning at p. 11) for more information.
4. The care program is adding new offerings including a mobile app and expanding the list of covered conditions (see p. 9 for more information).
5. Your Kairos team is growing! We now have a dedicated Participant Advocate Team (PAT) that answers your phone calls when you call our 888-phone number. We also have in-house nurses to help you navigate the health care system (see p. 8 for more information).
6. Allowable HSA contributions are going up, so you can save more money this year if you choose an applicable plan. See the HSA section for more info.

PLAN RULES

WHO'S ELIGIBLE?

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

WHEN CAN I MAKE A CHANGE?

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

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



DAYS

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?

YOU PAY

DEDUCTIBLE
The costs you cover on your own

YOU PAY, PLAN PAYS

COINSURANCE
The costs you share with the plan

YOU REACH YOUR OOP MAX

PLAN PAYS

COSTS OVER THE OOP MAX
Once you reach your out-of-pocket limit, the plan covers costs until the end of the plan year

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.
- ✓ **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 \$120 through mail order. It's like getting a month for free!
- ✓ **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.)
- ✓ **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



OUR NURSES HAVE PEOPLE EXCITEDLY SHOUTING:

“Health care is so complicated. I'm thankful you help us weed through it all!”







“You are a life saver! I hope you can hear when I ring that cowbell after last treatment!”

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
 \$25/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. (Not all employers offer, so please check with your employer for more information.)
- 
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. If you're a first responder, you get up to 12 one-on-one counseling sessions for a traumatic on-the-job event.

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

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

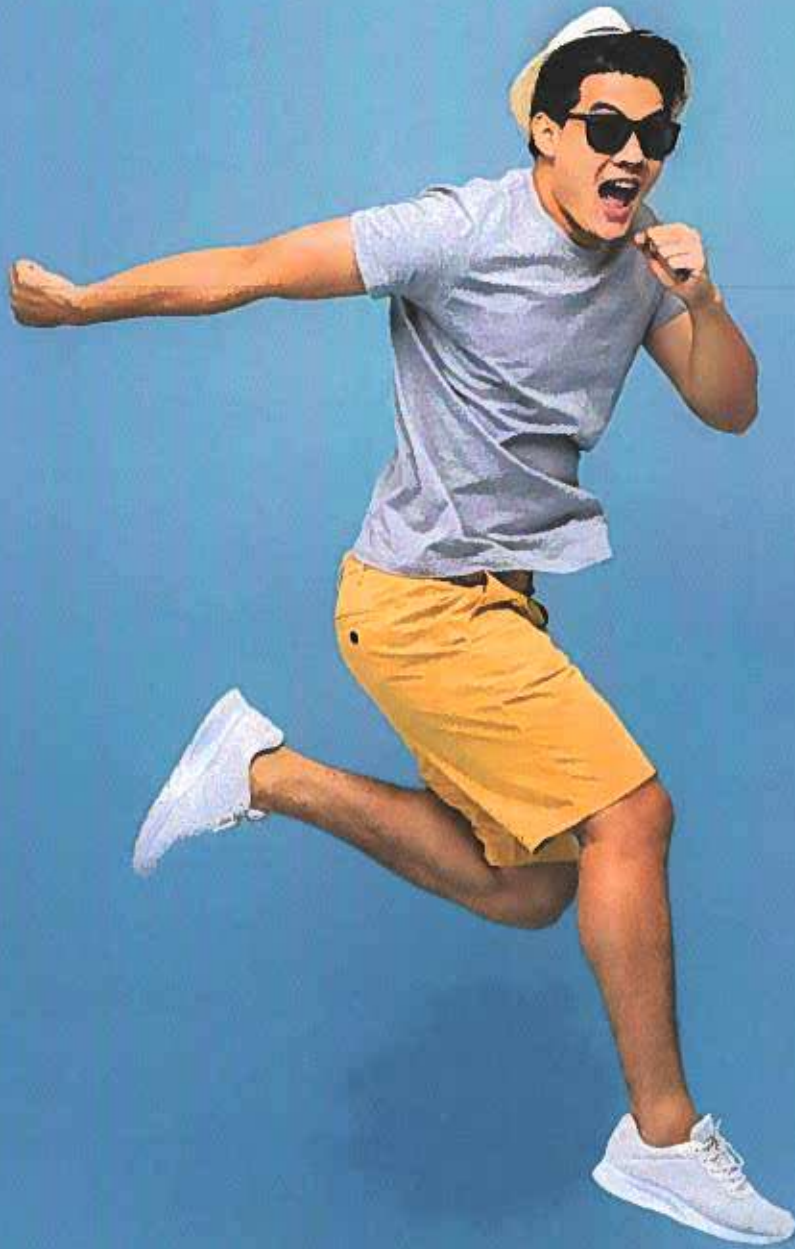
BONUS!

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: Kairos EAP



AND NOW... THE MEDICAL PLANS!



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

	IN-NETWORK ⁵	OUT-OF-NETWORK ⁵
DEDUCTIBLE¹	\$1,500/employee \$3,000/employee +1 or more	\$3,000/employee \$6,000/employee +1 or more
OUT-OF-POCKET MAXIMUM²	\$3,500/employee \$6,550/employee + 1 or more	No maximum
OFFICE VISITS		Deductible, then 50%
URGENT CARE	Deductible, then 20%	
EMERGENCY ROOM		Deductible, then 20%
WELLNESS SERVICES (ADULT/CHILD)		Deductible, then 50%
TELEHEALTH (TELADOC)³	No deductible, \$0	Not available
AMBULATORY SURGICAL CENTER		
NON-HOSPITAL INFUSION CENTER		
NON-HOSPITAL RADIOLOGY CENTER		
NON-HOSPITAL LAB/PATHOLOGY		
HOSPITAL RADIOLOGY		
HOSPITAL LAB/PATHOLOGY	Deductible, then 20%	Deductible, then 50%
AMBULANCE		
INPATIENT/OUTPATIENT HOSPITAL		
OUTPATIENT LAB AND X-RAY (INCLUDING MRI, PET, AND CT)		
OUTPATIENT BEHAVIORAL VISIT		

PRESCRIPTIONS

You must meet your annual medical deductible first, except for preventive medications⁴

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

¹This plan has 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.

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

³Teladoc 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.

⁴You must meet the annual medical plan deductible before the plan pays a prescription drug benefit, with the exception of certain preventive medications not subject to the deductible. For a detailed list of medications that are exempt from this rule under the HDHP plans, visit MaxorPlus.com.

⁵The 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.

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

	IN-NETWORK ⁵	OUT-OF-NETWORK ⁵
DEDUCTIBLE ¹	\$2,500/employee \$5,000/employee +1 or more	\$5,000/employee \$10,000/employee +1 or more
OUT-OF-POCKET MAXIMUM ²	\$3,450/employee \$6,550/employee + 1 or more	No maximum
OFFICE VISITS		Deductible, then 50%
URGENT CARE	Deductible, then 20%	
EMERGENCY ROOM		Deductible, then 20%
WELLNESS SERVICES (ADULT/CHILD)		Deductible, then 50%
TELEHEALTH (TELADOC) ³	No deductible, \$0	Not available
AMBULATORY SURGICAL CENTER		
NON-HOSPITAL INFUSION CENTER		
NON-HOSPITAL RADIOLOGY CENTER		
NON-HOSPITAL LAB/PATHOLOGY		
HOSPITAL RADIOLOGY		
HOSPITAL LAB/PATHOLOGY	Deductible, then 20%	Deductible, then 50%
AMBULANCE		
INPATIENT/OUTPATIENT HOSPITAL		
OUTPATIENT LAB AND X-RAY (INCLUDING MRI, PET, AND CT)		
OUTPATIENT BEHAVIORAL VISIT		

PRESCRIPTIONS

You must meet your annual medical deductible first, except for preventive medications⁴

RETAIL
(30-day supply)

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

MAIL ORDER
(90-day supply)

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

¹This plan has a non-embedded deductible and out-of-pocket maximum. This means that families enrolling in the plan will need to meet the entire family deductible before the plan pays benefits for any member of the family (other than preventive/wellness care). It also means that the out-of-pocket maximum applies to the family as a whole rather than to individual covered family members. All benefits are subject to deductible, unless noted otherwise. The medical plan deductible does not apply to retail and mail order prescription drug copays.

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

³Teladoc 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.

⁴You must meet the annual medical plan deductible before the plan pays a prescription drug benefit, with the exception of certain preventive medications not subject to the deductible. For a detailed list of medications that are exempt from this rule under the HDHP plans, visit MaxorPlus.com.

⁵The 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.

\$5,000 HDHP BENEFIT OVERVIEW

	IN-NETWORK ⁵	OUT-OF-NETWORK ⁵
DEDUCTIBLE ¹	\$5,000/employee \$10,000/employee +1 or more	\$10,000/employee \$20,000/employee +1 or more
OUT-OF-POCKET MAXIMUM ²	\$6,450/employee \$12,900/employee + 1 or more	No maximum
OFFICE VISITS		
URGENT CARE	Deductible, then 20%	Deductible, then 50%
EMERGENCY ROOM		Deductible, then 20%
WELLNESS SERVICES (ADULT/CHILD)		Deductible, then 50%
TELEHEALTH (TELADOC) ³	No deductible, \$0	Not available
AMBULATORY SURGICAL CENTER		
NON-HOSPITAL INFUSION CENTER		
NON-HOSPITAL RADIOLOGY CENTER		
NON-HOSPITAL LAB/PATHOLOGY		
HOSPITAL RADIOLOGY		
HOSPITAL LAB/PATHOLOGY	Deductible, then 20%	Deductible, then 50%
AMBULANCE		
INPATIENT/OUTPATIENT HOSPITAL		
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MAIL ORDER (90-day supply)	<ul style="list-style-type: none"> • Generic: \$20 • Preferred: \$120 • Non-preferred: \$220

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

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

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

⁴You must meet the annual medical plan deductible before the plan pays a prescription drug benefit, with the exception of certain preventive medications not subject to the deductible. For a detailed list of medications that are exempt from this rule under the HDHP plans, visit MaxorPlus.com.

⁵The 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/gme.

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.



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	\$3,650
FAMILY	\$7,300
AGE 55+	Additional \$1,000



Learn how to maximize your HSA



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

BASIC LIFE AND AD&D INSURANCE

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

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

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




PET INSURANCE

Pet insurance pays, partly or in total, the cost of veterinary treatment for your ill or injured pet.

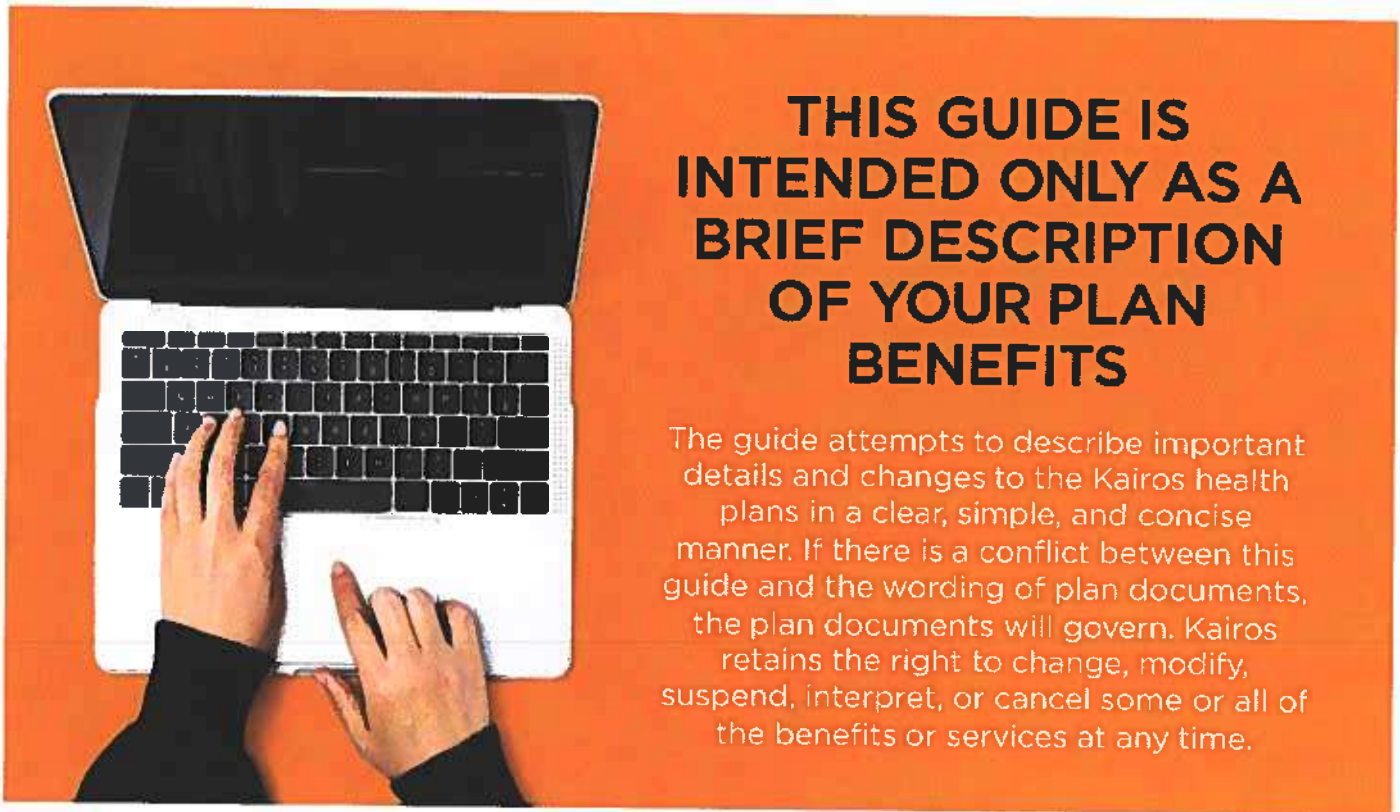
The My Pet Protection plans from Nationwide help you provide your pets with the best care possible:

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

To enroll your cat or dog, visit petinsurance.com/kairoshealthaz.
To enroll your bird, rabbit, reptile, or other exotic pet, call 877.738.7874



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



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

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

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

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

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

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

PRIVACY NOTICE REMINDER

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

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

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

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

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

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

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

MID-YEAR CHANGES TO YOUR HEALTH CARE BENEFIT ELECTIONS

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

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

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

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

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

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

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

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

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

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

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

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

PAPERWORK REDUCTION ACT STATEMENT

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

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

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

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

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

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

COBRA COVERAGE REMINDER

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

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

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

In addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. You may wish to seek coverage through the Health Insurance Marketplace. (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 October 15, 2021. Contact your state for more information on eligibility.

<p>ALABAMA – Medicaid</p> <p>Website: myalhipp.com/ Phone: 855.692.5447</p>	<p>CALIFORNIA – Medicaid</p> <p>Health Insurance Premium Payment (HIPP) Program website: dhcs.ca.gov/hipp Phone: 916.445.8322 Email: hjpp@dhcs.ca.gov</p>
<p>ALASKA – Medicaid</p> <p>The AK Health Insurance Premium Payment Program Website: myakhipp.com/ Phone: 866.251.4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</p>	<p>COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)</p> <p>Health First Colorado Website: healthfirstcolorado.com/ Health First Colorado Member Contact Center: 800.221.3943/ State Relay 711 CHP+: colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 800.359.1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442</p>
<p>ARKANSAS – Medicaid</p> <p>Website: myarhipp.com/ Phone: 855.692.7447</p>	<p>FLORIDA – Medicaid</p> <p>Website: flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 877.357.3268</p>
<p>GEORGIA – Medicaid</p> <p>Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678.564.1162 ext 2131</p>	<p>MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: mass.gov/info-details/masshealth-premium-assistance-pa Phone: 800.862.4840</p>
<p>INDIANA – Medicaid</p> <p>Healthy Indiana Plan for low-income adults 19-64 Website: in.gov/fssa/hip/ Phone: 877.438.4479 All other Medicaid Website: in.gov/medicaid/ Phone: 800.457.4584</p>	<p>MINNESOTA – Medicaid</p> <p>Website: mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 800.657.3739</p>
<p>IOWA – Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: dhs.iowa.gov/ime/members Medicaid Phone: 800.338.8366 Hawki Website: dhs.iowa.gov/Hawki Hawki Phone: 800.257.8563 HIPP Website: dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 888.346.9562</p>	<p>MISSOURI – Medicaid</p> <p>Website: dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573.751.2005</p>
<p>KANSAS – Medicaid</p> <p>Website: kancare.ks.gov/ Phone: 800.792.4884</p>	<p>MONTANA – Medicaid</p> <p>Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 800.694.3084</p>
<p>KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 855.459.6328 Email: KIHIPPROGRAM@ky.gov</p> <p>KCHIP Website: kidshealth.ky.gov/Pages/index.aspx Phone: 877.524.4718</p> <p>Kentucky Medicaid Website: chfs.ky.gov</p>	<p>NEBRASKA – Medicaid</p> <p>Website: ACCESSNebraska.ne.gov Phone: 855.632.7633 Lincoln: 402.473.7000 Omaha: 402.595.1178</p>

LOUISIANA - Medicaid Website: medicaid.la.gov or ldh.la.gov/lahipp Phone: 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)	NEVADA - Medicaid Medicaid Website: dhcfr.nv.gov Medicaid Phone: 800.992.0900
MAINE - Medicaid Enrollment Website: maine.gov/dhhs/ofi/applications-forms Phone: 800.442.6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: maine.gov/dhhs/ofi/applications-forms Phone: 800.977.6740 TTY: Maine relay 711	NEW HAMPSHIRE - Medicaid Website: dhhs.nh.gov/oi/hipp.htm Phone: 603.271.5218 Toll free number for the HIPP program: 800.852.3345, ext 5218
NEW JERSEY - Medicaid and CHIP Medicaid Website: state.nj.us/humanservices/ Medicaid Phone: 609.631.2392 CHIP Website: njfamilycare.org/index.html CHIP Phone: 800.701.0710	SOUTH DAKOTA - Medicaid Website: dss.sd.gov Phone: 888.828.0059
NEW YORK - Medicaid Website: health.ny.gov/health_care/medicaid/ Phone: 800.541.2831	TEXAS - Medicaid Website: gethipptexas.com/ Phone: 800.440.0493
NORTH CAROLINA - Medicaid Website: medicaid.ncdhhs.gov/ Phone: 919.855.4100	UTAH - Medicaid and CHIP Medicaid Website: medicaid.utah.gov/ CHIP Website: health.utah.gov/chip Phone: 877.543.7669
NORTH DAKOTA - Medicaid Website: nd.gov/dhs/services/medicalserv/medicaid/ Phone: 844.854.4825	VERMONT - Medicaid Website: greenmountaincare.org/ Phone: 800.250.8427
OKLAHOMA - Medicaid and CHIP Website: insureoklahoma.org Phone: 888.365.3742	VIRGINIA - Medicaid and CHIP Website: coverva.org/en/famis-select coverva.org/en/hipp Medicaid and CHIP Phone: 800.432.5924
OREGON - Medicaid Website: healthcare.oregon.gov/Pages/index.aspx oregonhealthcare.gov/index-es.html Phone: 800.699.9075	WASHINGTON - Medicaid Website: hca.wa.gov/ Phone: 800.562.3022
PENNSYLVANIA - Medicaid Website: dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 800.692.7462	WEST VIRGINIA - Medicaid Website: mywvhipp.com Phone: 855.699.8447
RHODE ISLAND - Medicaid and CHIP Website: sohhs.ri.gov/ Phone: 855.697.4347 or 401.462.0311 (Direct Rite Share Line)	WISCONSIN - Medicaid and CHIP Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 800.362.3002
SOUTH CAROLINA - Medicaid Website: scdhhs.gov Phone: 888.549.0820	WYOMING - Medicaid Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 800.251.1269

To see if any other states have added a premium assistance program since October 15, 2021, 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