A Guide to Your Benefits

2021-2022

KRMC
KINGMAN REGIONAL MEDICAL CENTER

Enrolling in Your Benefits

- Log in at https://azkrmc.kronos.net/wfc/logon
- Begin the benefits enrollment process
- Elect the benefits you want
- Save or submit your elections
- Print a copy of your elections for your records

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Your KRMC benefits

We understand the important role that benefits play in the lives of you and your family. During open enrollment, you have an opportunity to make changes to your benefits package to ensure you and your family have the right coverage.

This benefits guide can help familiarize you with KRMC's benefit options. It also provides useful tips, tools and resources to help you think through your options and make wise decisions. As you prepare to enroll:

- Consider your benefit coverage needs for the upcoming year. For example, is your family financially protected if you can't work due to an accident or illness?
- Gather information you'll need. If you are covering dependents, you will need their dates of birth and Social Security numbers. In addition, you may need to provide legal documentation verifying their eligibility — such as a marriage certificate or birth certificate.

Getting the most value from your benefits depends on how well you understand your plans and how you choose to use them. Be sure to read this entire guide for important information about your benefit options.

Letter from the Benefits Team

At Kingman Regional Medical Center (KRMC), our benefit plans are designed to recognize the diverse needs of our employees.

We strive to:

- Maintain a program that considers individual needs;
- Provide competitive and comprehensive benefit options that allow you to select the plans based on your own needs, and;
- Provide long-term financial security for you and your family.

As we reviewed our benefits, we've decided to make some enhancements to continue to provide you with benefit options that fit your needs.

First, to recognize the challenges over the last year, your medical plan costs will be the same as last year. KRMC will absorb the cost increases so that you will pay the same rates that you paid last year for the PPO $500 and HDHP $2,800 Plan. Plus you will have a new medical plan option to choose from this year, a HDHP with a $1,400 deductible.

To ensure you can cover your family properly for dental and vision, we are expanding the number of coverage tiers so you can select employee only, employee + spouse, employee + child(ren) or employee + family coverage.

We also want you to have access to any support you may need. That's why we are introducing a new EAP program, IBH to help you if you have anxiety/depression, or you need help with financial or legal issues.

Open Enrollment, from May 3 to 23, 2021, is your once-a-year opportunity to re-evaluate your current elections and ensure you make **Smart Choices** for you and your family. All changes will be effective on July 1, 2021. To help you learn more about your benefits, a Virtual Health Fair will be offered May 3 to 7, 2021.

It is our goal to provide you with the necessary information and tools to make informed decisions about your benefits. We appreciate your continued hard work and dedication. If you have any questions, please contact Human Resources at 928-757-0600 option 1 or via email at HumanResourcesBenefits@azkrmc.com.

Eligibility

Full-time employees who work at least 32 hours per week are eligible for the benefits described in this guide.

Benefits are effective on the first day of the month following your date of hire. The following dependents are also eligible:

- Your legal spouse
- Your children up to age 26

Changes to your benefits

Generally, you may only make or change your existing benefit elections as a new hire or during the annual open enrollment period. However, you may change your benefit elections during the year if you experience a qualified event such as:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Loss or gain of other coverage by the employee or dependent
- Eligibility for Medicaid

You have 31 days from the qualified life event to make changes to your coverage. Depending on the type of event, you may need to provide proof of the event, such as a marriage certificate. If you do not make the changes within 31 days of the qualified event, you will have to wait until the next open enrollment period to make changes (unless you experience another qualified life event).

Eligible Dependent Documents

- Marriage Certificate
- Birth Certificate
- Adoption: Official Court Documents & State Birth Certificate
- Stepchild: Marriage Certificate and Birth Certificate
- Legal Guardianship: Official Court Documents

For additional information, please visit the KRMC benefits intranet page.

Medical and pharmacy plan overview

We offer the choice of three medical plans through BlueCross BlueShield of Arizona. The medical options include coverage for prescription drugs. To select the plan that best suits your family, you should consider the key differences between the plans, the cost of coverage (including payroll deductions), and how the plans cover services throughout the year.

Understanding how your plan works

1. Your deductible

You pay out-of-pocket for most medical and pharmacy expenses, except those with a copay, until you reach the deductible.

You can pay for these expenses from your Health Savings Account (HSA) or Flexible Spending Account (FSA).

2. Your coverage

Once your deductible is met, you and the plan share the cost of covered medical and pharmacy expenses. The plan will pay a percentage of each eligible expense, and you will pay the rest.

3. Your out-of-pocket maximum

When you reach your out-of-pocket maximum, the plan pays 100% of covered medical and pharmacy expenses for the rest of the plan year. Your deductible and coinsurance apply toward the out-of-pocket maximum.

Employees with dependent coverage, the family deductible works differently depending on the plan.

The difference between non-embedded and embedded deductibles and out-of-pocket maximums

- **The HDHP $1,400 Plan has a non-embedded approach.** There is one family limit that applies to all of you. When one or a combination of family members has expenses that meet the family deductible or out-of-pocket maximum, it is considered to be met for all of you. Then, the plan will begin paying its share of eligible expenses for the whole family for the rest of the year.
- **The HDHP $2,800 Plan has an embedded approach.** Each person only needs to meet the individual deductible and out-of-pocket maximum before the plan begins paying its share for that individual. (And, once two or more family members meet the family limits, the plan begins paying its share for all covered family members.)

Making the most of your plan

Getting the most out of your plan also depends on how well you understand it. Keep these important tips in mind when you use your plan.

- **In-network providers and pharmacies:** You will always pay less if you see a provider within the medical and pharmacy network.
- **Preventive care:** In-network preventive care is covered at 100% (no cost to you). Preventive care is often received during an annual physical exam and includes immunizations, lab tests, screenings and other services intended to prevent illness or detect problems before you notice any symptoms. For a full list of Preventive Services Covered Under the Affordable Care Act, please visit https://www.healthcare.gov/coverage/preventive-care-benefits/.
- **Mail Order Pharmacy:** If you take a maintenance medication on an ongoing basis for a condition like high cholesterol or high blood pressure, you can use the Mail Order Pharmacy to save on a 90-day supply.
- **Pharmacy coverage:** Medications are placed in categories based on drug cost, safety and effectiveness. These tiers also affect your coverage.
  - **Generic** – A drug that offers equivalent uses, doses, strength, quality and performance as a brand-name drug, but is not trademarked.
  - **Brand preferred** – A drug with a patent and trademark name that is considered “preferred” because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.
  - **Brand non-preferred** – A drug with a patent and trademark name. This type of drug is “not preferred” and is usually more expensive than alternative generic and brand preferred drugs.
  - **Specialty** – A drug that requires special handling, administration or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.

Medical and pharmacy coverage

Medical Plan Provisions	HDHP $2,800		HDHP $1,400		PPO $500	
	Tier 1 KHI Provider	Tier 2 BCBS In-Network Provider	Tier 1 KHI Provider	Tier 2 BCBS In-Network Provider	Tier 1 KHI Provider	Tier 2 BCBS In-Network Provider
Company contribution to HSA (Individual/Family)	$500/$1,000		$500/$1,000		N/A	
Annual Deductible (Individual/Family)	$2,800/ $5,600	$3,500/ $7,000	$1,400/ $2,800	$3,500/ $7,000	$500/ $1,500	$2,250/ $4,500
Out-of-Pocket Maximum (Includes Deductible)	$6,000/ $12,000	$6,750/ $13,500	$4,000/ $8,000	$6,750/ $13,500	$2,250/ $4,500	$5,000/ $15,000
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Primary Care Provider Office Visit	10%*	35%*	10%*	30%*	$30 copay	$45 copay
Specialist Office Visit	10%*	35%*	10%*	30%*	$40 copay	$55 copay
X-Ray and Lab	10%*	35%*	10%*	30%*	10%*	30%*
Inpatient Hospital Services	10%*	35%*	10%*	30%*	10%*	30%*
Outpatient Hospital Services	10%*	35%*	10%*	30%*	10%*	30%*
Urgent Care	10%*	35%*	10%*	30%*	$50 copay; ded. does not apply	$125 copay; ded. does not apply
Emergency Room	10%*	35%*	10%*	30%*	$150 copay; ded. does not apply	$250 copay; ded. does not apply
Retail Pharmacy (up to a 30-day supply)						
Generic	10%*	35%*	10%*	30%*	$10	$15
Brand Preferred	10%*	35%*	10%*	30%*	$25	$45
Brand Non-Preferred	10%*	35%*	10%*	30%*	$45	$60
Specialty	10%*	35%*	10%*	30%*	$75	$100
Mail Order Pharmacy (90-day supply)						
Generic	10%*	35%*	10%*	30%*	$20	$30
Brand Preferred	10%*	35%*	10%*	30%*	$50	$90
Brand Non-Preferred	10%*	35%*	10%*	30%*	$90	$120

*After deductible

Medical and pharmacy coverage

Medical Plan Provisions	HDHP $2,800 Out-of-Network	HDHP $1,400 Out-of-Network	PPO $500 Out-of-Network
Annual Deductible (Individual/Family)	$5,400/$10,800	$5,400/$10,800	$6,750/$13,500
Out-of-Pocket Maximum (Includes Deductible)	Unlimited	Unlimited	Unlimited
Preventive Care	50%*	50%*	50%*
Primary Care Provider Office Visit	50%*	50%*	50%*
Specialist Office Visit	50%*	50%*	50%*
X-Ray and Lab	50%*	50%*	50%*
Inpatient Hospital Services	50%*	50%*	50%*
Outpatient Hospital Services	50%*	50%*	50%*
Urgent Care	50%*	50%*	50%*
Emergency Room	35%*	30%*	$250 copay; ded. does not apply
Retail Pharmacy (up to a 30-day supply)			
Generic	Not covered	Not covered	Not covered
Brand Preferred	Not covered	Not covered	Not covered
Brand Non-Preferred	Not covered	Not covered	Not covered
Specialty	Not covered	Not covered	Not covered
Mail Order Pharmacy (90-day supply)			
Generic	Not covered	Not covered	Not covered
Brand Preferred	Not covered	Not covered	Not covered
Brand Non-Preferred	Not covered	Not covered	Not covered
Specialty	Not covered	Not covered	Not covered

*After deductible

KRMC's wellness program

Good health is priceless and the everyday choices we make help us live healthier, happier, and more fulfilling lives, both at work and home. KRMC wants to support all employees on their health journey.

Insurance Premium Reduction

KRMC offers full-time benefits-eligible employee and their covered spouses a chance to earn an insurance premium reduction of $720 - $1,080 a year by participating in the KRMC wellness program. The Wellness Program begins on July 01, 2021.

To earn the Insurance Premium Reduction, employees must:

1. Register with Sharecare at azblue.sharecare.com
2. Complete challenges and participate in wellness initiatives to earn 400 points by May 31, 2022.

   Options include:

   - Real Age Health Assessment (50 points)
   - Biometrics through Home Test Kit or Physician Form (50 points)
   - Quarterly Sharecare challenges (125 points each)
   - Preventive exam (50 points)
   - KRMC opportunities such as volunteering, 5k walk/run (75 points each)
   - Educational webinars (50 points each)

Culture of Health

Our vision is that all employees feel supported in their well-being efforts. To help us achieve our vision we will be recruiting a wellness committee to provide direction for the program and ensure we are meeting the needs of all employees. The wellness program will focus on the six dimensions of Well-being: Mental, Emotional, Physical, Financial, Social, and Occupational. Each quarter there will be a new theme and employees will have access to challenges, resources, and awareness messaging to support these areas of wellbeing.

Quarter	Theme
July – September 2021	Health & Wellness Safety
October – December 2021	Emotional well-being
January – March 2022	New Year, New You
April – June 2022	Healthy Lifestyle

Non-Tobacco User Credit

During Open Enrollment, you will attest to your tobacco status (and that of your spouse) when you enroll in your benefits using Kronos Employee Self-Service. To receive the Non-Tobacco User discount, you will need to complete the Non-Tobacco attestation through Kronos during Open Enrollment. If you do not complete the attestation, you will be ineligible to receive the non-tobacco discount regardless of your tobacco status. This attestation is required during open enrollment as it is only effective during each benefit plan year.

For any other questions regarding the KRMC Wellness Program, please contact Human Resources at HumanResourcesBenefits@azkrmc.com or by calling 928-757-0600 option 1. For further information, check out the benefits intranet page.

Savings accounts

KRMC offers several accounts that enable you to pay for eligible expenses tax-free through Health Equity. The IRS provides a list of eligible expenses for each account at https://www.irs.gov/publications/p969.

Health Savings Account (HSA)

Available to those enrolled in the HDHP as long as you are not enrolled in any other health coverage or Medicare, or claimed as a dependent on someone else's tax return.

Health Care Flexible Spending Account (FSA)

Available to those enrolled in the PPO plan. Use this account for eligible medical, pharmacy, dental and vision expenses.

Dependent Care Flexible Spending Account (FSA)

This option is available to those enrolled in either the HDHP or the PPO plan. Use this Dependent Care FSA for eligible childcare expenses for dependents under age 13 or elder care.

Comparison of accounts

	HSA	FSA
Does the company contribute? *Amount for full-year 2021*	✓ Employee: $500 Employee + 1 or Family: $1,000	✗
Can I contribute my own savings?	✓	✓
Is there an IRS maximum annual contribution?	✓ Employee: $3,600 Family: $7,200 Those 55 and older can contribute an additional $1,000 annually.	✓ Health Care FSA: $2,750 Dependent Care FSA: $5,000
Will my savings roll over each year?	✓ Unlimited	! Up to $500 for Health Care FSA; No rollover for Dependent Care FSA
Will I earn interest on my savings?	✓	✗
Are the savings tax-free? *In most states*	✓	✓
Do I keep the money if I leave the company?	✓	✗
Can I also have a Flexible Spending Account (FSA)?	Dependent Care FSA only	N/A

If you are newly enrolled in any of these savings plans, you will receive a welcome kit with additional information and, if applicable, your debit card. Please note: you will not receive a card for the dependent care FSA.

For additional information, contact Health Equity at 866-346-5800 or visit their website at www.healthequity.com.

Health savings account

A Health Savings Account (HSA) is a savings account that belongs to you that is paired with the HDHP. It allows you to make tax-free contributions to a savings account to pay for current and future qualified health care expenses for you and your dependents.

START IT

- Contributions to the HSA are tax-free for you whether they come from you or the company. KRMC contributes $500 for individual coverage and $1,000 for family coverage.
- Plans with an HSA typically cost less than other plans so the money you save on premiums can be put into your HSA. You save money on taxes and have more flexibility and control over your health care dollars.

BUILD IT

- All of the money in your HSA is yours (including any contributions deposited by KRMC) even if you leave your job, change plans or retire.
- In 2021, the total of your contributions and the company's can be up to $3,600 for individual coverage and $7,200 for family coverage.

USE IT

- You can withdraw your money tax-free at any time, as long as you use it for qualified expenses (a list can be found on https://www.irs.gov/publications/p969).
- You can also save this money and hold onto it for future eligible health care expenses.

GROW IT

- Unused money in your HSA will roll over, earn interest and grow tax-free over time.
- You decide how to use the HSA money, including whether to save it or spend it for eligible expenses. When your balance is large enough, you can invest it — tax-free.

Eligibility Details

- If you are age 55 or older, you can contribute an additional $1,000 per year.
- You are not allowed to be enrolled in any other health coverage, and cannot have an HSA if you are enrolled in any other health coverage or Medicare, or claimed as a dependent on someone else's tax return.
- You cannot participate in the Health Care Flexible Spending Account (FSA) if you have an HSA. Your spouse also cannot have a Health Care FSA.

Flexible spending accounts

A Flexible Spending Account (FSA) helps you pay for health care or dependent care using tax-free dollars. Your contribution is deducted from your paycheck on a pretax basis and is put into the FSA. When you incur expenses, you can access the funds in your account to pay for eligible expenses. This chart shows the eligible expenses for each FSA and how much you can contribute each year. Each of these options reduces your taxable income.

Account type	Eligible expenses	Annual contribution limits
Health Care FSA	Most medical, dental and vision care expenses that are not covered by your health plan (such as copays, coinsurance, deductibles, eyeglasses and prescriptions)	Maximum contribution is $2,750 per year. You cannot enroll if you are enrolled in the HDHP with an HSA. Funds are deducted throughout the year, but all funds are available on July 1.
Dependent Care FSA	Dependent care expenses (such as day care, after school programs or elder care programs) for children under age 13 or elder care so you and your spouse can work or attend school full-time	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns).

Important information about FSAs

Your FSA elections are effective from July 1 through June 30. Claims for reimbursement must be submitted by September 30 of the following year. Our Health Care FSA allows you to carry over $500 in unused funds to the following plan year.

Please plan your contributions carefully. Any unused money remaining in your account(s) will be forfeited. This is known as the “use it or lose it” rule and it is governed by Internal Revenue Service regulations. Note that FSA elections do not automatically continue from year to year; you must actively enroll each year.

Dental plan

It's important to have regular dental exams and cleanings so problems are detected before they become painful — and expensive. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and is an important part of maintaining your overall health. We offer a dental plan through Delta Dental of Arizona.

Benefits	PPO Dentist	Premier Dentist	Out-of-Network Dentist
Calendar Year Deductible		$25 Individual / $75 Family	
Calendar Year Maximum		$1,000 Per Person	
Preventive Care • Exams, Cleanings, X-rays, Fluoride Treatments	100% deductible waived	100% deductible waived	100% deductible waived
Basic Services • Filings, Endodontics, Periodontics, Simple Oral Surgery	85% after deductible	85% after deductible	85% after deductible
Major Services • Bridges, Dentures, Implants, Crowns	60% after deductible	60% after deductible	60% after deductible
Orthodontics • Child & Adult (ages 8 and older)		50% $1,000 lifetime maximum	

Using in-network dental providers

While you have the option of choosing any provider, you will save money when you use in-network dentists. When using an out-of-network dental provider, you will pay more because the provider has not agreed to charge you a negotiated rate.

For more information, log on to Delta Dental at www.deltadentalaz.com or call 800-352-6132, option 1.

Vision plan

The vision plan provides coverage for routine eye exams and pays for all or a portion of the cost of glasses or contact lenses. You can choose any provider; however, you always save money if you see in-network providers. We offer two vision plan choices through VSP® Vision Care. Log on to www.vsp.com for more information.

Plan Provisions	Base Plan		Buy-Up Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Exam	$10 copay	Up to $50	$10 copay	Up to $50
Frames	Coverage up to $130-$150 (additional discounts for more frames than allowed)	Up to $70	Coverage up to $160-$180 (additional discounts for more frames than allowed)	Up to $70
Lenses				
• **Single vision lenses**	$15 copay	Up to $50	$15 copay	Up to $50
• **Bifocal lenses**	$15 copay	Up to $75	$15 copay	Up to $75
• **Trifocal lenses**	$15 copay	Up to $100	$15 copay	Up to $100
• **Progressive lenses**	$15 copay	Up to $75	$15 copay	Up to $75
Contact Lenses				
• **Instead of glasses**	$130 allowance; no copay	Up to $60	$150 allowance; no copay	Up to $60
Diabetic Eyecare Plus Program	$20 copay	Not covered	$20 copay	Not covered
Frequency				
• **Exam**	12 months	12 months	12 months	12 months
• **Lenses**	24 months	24 months	12 months	12 months
• **Frames**	24 months	24 months	12 months	12 months
• **Contact lenses**	24 months	12 months	12 months	12 months

Please keep in mind that you will not receive an insurance card. Just let your provider know that you are a KRMC employee with VSP coverage!

Life insurance and disability

Basic Life and AD&D Insurance – Gallagher

Life insurance is an important part of your financial wellbeing, especially if others depend on you for support. KRMC provides basic life and accidental death and dismemberment insurance at **no cost** with a maximum benefit of $30,000. Coverage is automatic; you do not need to enroll.

Voluntary Life and AD&D Insurance – Gallagher

You may choose to purchase additional life and AD&D coverage for yourself and your dependents at affordable group rates. Rates are based on age and the coverage level chosen.

Voluntary Life and AD&D Insurance for you

Employee

- Increments of $10,000 up to 5x your base annual salary
- Up to a $500,000 maximum
- Guaranteed issue up to $200,000

Voluntary Life and AD&D Insurance for your dependents

Spouse

- Increments of $5,000
- Up to a $500,000 maximum
- May not exceed 100% of the employee's amount

Child(ren)

- $10,000 per child

Additional Whole Life Insurance – Transamerica

Life is unpredictable. Universal life insurance offers help that goes beyond traditional life insurance to meet challenging situations. If you need to borrow against the cash value, you can pay it back when times get better.

If you're diagnosed with a terminal illness, you can use a portion of the policy's death benefit to make a difficult time easier.

If you're laid off, monthly deductions are waived for up to six months so you maintain your policy.

Eligibility

You can insure your eligible spouse, children, and grandchildren (only applies to the Whole Life insurance) with their own policies or purchase protection for your children through a child level term life insurance rider. The chart below gives the ages at which you and family members may apply, but all universal life policies can be maintained up to age 100.

	Age Limit	Benefit
Self	Ages 16 through 80	$150,000 benefit
Spouse or equivalent by law	Ages 16 through 65	$15,000 benefit
Children/ grandchildren	Ages 0 through 25 years	$25,000 benefit
Children under optional child term rider	Ages 15 days through 25 years	$20,000 benefit

Policy is portable

You have the option to keep your Voluntary Life and AD&D and/or Whole Life insurance policies after you separate from employment. Your Voluntary Life and AD&D policy allows you to transfer your current coverage amount to an individual policy to ensure you and your family are covered.

Your Whole Life policy allows you to adjust premiums, death benefits and cash value amounts to meet changing personal financial situations.

Disability Insurance

Disability insurance provides income replacement should you become disabled and unable to work due to a non-work-related illness or injury. KRMC provides disability coverage at **no cost** as shown below. Coverage is automatic; you do not need to enroll.

Coverage	Benefit
Short-Term Disability	• 70% of your base pay for non-work related injuries • Benefit begins after 7 consecutive days of disability/illness for a maximum of 90 days
Long-Term Disability (Reliance Standard)	• Covers 50% of your base annual earnings, to a $17,500 maximum • Benefit begins after 90 days of disability • Benefits are offset with other sources of income, such as Social Security and Workers' Compensation.

Family Medical Leave Act (FMLA)

If you have been with the company for 12 months and worked 1,250 hours, you may be eligible for up to 12 work weeks of unpaid leave under the Family and Medical Leave Act (FMLA). FMLA can be used for an illness of your own, care needed for a family member, care for a newborn, an injured service member, and certain other medical needs. For additional information or to request leave, visit www.fmlasource.com or call 877-462-3652.

Voluntary plans

Group Accident Insurance – Reliance Standard

Accident Insurance provides benefits to help cover the costs associated with unexpected bills due to covered accidents, regardless of any other insurance you have. If you purchase coverage and are hurt in a covered accident, you will receive a cash benefit for covered injuries that you may spend as you like.

Coverage amounts

Voluntary Group Accident Insurance
Cash benefit based on type of accident (ranges from $35 - $15,000)

Examples of covered injuries:

- Broken bones
- Burns
- Torn ligaments
- Cuts repaired by stitches
- Eye injuries
- Ruptured discs
- Concussion

Individual Short-Term Disability Insurance – UNUM

If you become sick or injured and can't work, this insurance can replace part of your income while you recover. As long as you remain disabled, you can receive payments for up to 6 months depending on the plan you choose.

Choose a monthly benefit between $400 and $3,000 for covered disabilities due to injury or illness. Coverage of up to 60% of your gross monthly salary may be offered. You may have to answer some additional health questions.

Critical Illness Insurance – Reliance Standard

Critical Illness Insurance provides cash to help pay for both medical expenses not covered by your medical plan as well as day-to-day expenses that may start to add up — like rent, mortgage, car payments, etc. — while you are ill. With Critical Illness Insurance, if you are diagnosed with a covered illness, you get a lump-sum cash benefit, even if you receive other insurance benefits.

Coverage amounts

Employee	Spouse	Child(ren)
• Increments of $1,000 • Choose from a benefit of $5,000 to a maximum of $50,000	• Increments of $1,000 • Choose from a benefit of $5,000 to a maximum of $50,000 • Benefit cannot exceed 100% of approved employee amount	• 25% of approved employee amount • Up to a maximum of $12,500

Examples of covered illnesses:

- Cancer
- Heart attack
- Major organ failure
- End-stage renal (kidney) failure
- Coronary artery bypass graft surgery
- Stroke

Your initial benefit provides a lump-sum payment upon the first diagnosis of a covered condition. Your plan pays a recurrence benefit for the same illness at 100% if diagnosed 6 months or later. A subsequent occurrence benefit of 100% is paid if diagnosed 3 months of later.

Employee assistance programs

Confidential and professional assessment and referral services for employees and their family members.

ACI EAP Program

The EAP provides professional and confidential services to help employees and family members address a variety of personal, family, life, and work-related issues.

EAP and Work-Life Benefits:

From the stress of everyday life to relationship issues or even work-related concerns, the EAP can help with any issue affecting overall health, well-being and life management.

- Unlimited telephonic clinical assessment and referral
- Up to 3 sessions of professional assessment for employees and family members
- Unlimited child care and elder care referrals
- Legal consultation for unlimited number of issues per year
- Financial consultation for unlimited number of issues per year
- Unlimited pet care consultation
- Unlimited education referrals and resources
- Unlimited referrals and resources for any personal service
- Unlimited Community-based resource referrals
- Online legal resource center
- Affinity™ online work-life website
- myACI app for mobile access
- Multicultural and multilingual providers available nationwide

EAP benefits are free of charge, 100% confidential, available to all family members regardless of location, and easily accessible through ACI's 24/7, live-answer, toll-free number.

EAP services are provided by ACI Specialty Benefits, under agreement with Reliance Standard Life Insurance Company.

Additional Questions?

Contact ACI Specialty Benefit toll-free at:
855-RSL-HELP
(855-775-4357)
RSLI@ACIEAP.com
http://rsli.acieap.com

IBH EAP Program – NEW!

The EAP Can Help with Almost Any Issue

EAP benefits are available to all employees and their families at NO COST to you. Help is just a phone call away. The EAP offers confidential advice, support, and practical solutions to real-life issues. You can access these confidential services by calling the toll-free number and speaking with a consultant.

EAP Services for Employees and Families

Confidential Counseling: Up to five face-to-face, video or telephonic counseling sessions for relationship and family issues, stress, anxiety, and other common challenges. If additional support is needed, IBH is integrated with the medical plans and will work with BCBSAZ to find you an in-network provider.

Tess, AI Chat-bot:

24/7 chatbot for emotional support and check-ins to boost wellness. Text “Hi” to +1-650-825-9634 to get started.

Peer Support Groups:

Online support groups for addiction, depression, bipolar, anxiety, parenting, LGBTQ+, and frontline workers.

Online Resources at ibhsolutions.com/members

ibhsolutions.com/members:
Access life-balance and wellbeing resources, monthly webinars, newsletters, and more.

EAP App:

Easy access to information about the EAP, upcoming events and resources (search for “IBH Mobile” in the App Store).

Lunch + Learn Webinars:

Industry experts will present live monthly employee and supervisor webinars on a variety of topics, followed by Q+A.

Your EAP provides a wide range of work-life balance services to help you survive a variety of challenges:

- Childcare
- Legal Service
- College Planning Program
- Financial Help
- Identity Theft Service
- Mediation Service

Access Counseling and Benefit Information

Call: 800-395-1616
Website: ibhsolutions.com/members

- Click on the IBH logo
- Username: IBHEAP
- Password: WL0103
- Click the My Benefits button

BlueCare Anywhere

BlueCare Anywhere is a 24/7 service providing access to board-certified doctors by mobile app, online video or telephone. Whether you are at home, at work, traveling or you simply want a more convenient way to see a doctor. It is easy to use and available anytime, anywhere.

The cost per visit will vary based on your medical plan:

- **PPO Plan:** $30 copay
- **HDHP Plan:** You pay 10% after your deductible has been met

To access participating BlueCare Anywhere providers: Enroll online at www.BlueCareAnywhereAZ.com.

1. Select a provider type (medical, counseling or psychiatry) and complete a questionnaire explaining your symptoms and medical history.
2. Choose a doctor, list your pharmacy (if medication is required) and schedule your appointment.
3. Pay applicable cost share (comparable to an office visit) with a credit card, FSA or HSA.
4. After your visit, you will receive a report you can share with other healthcare providers regarding your condition.

Remember: If your family members are covered under your health plan, they are also eligible to utilize BlueCare Anywhere services.

Use Virtual Visits for:	Choose Other Care for:
• Allergies • Bladder Infection • Bronchitis • Cough/Cold • Fever • Nausea • Pink Eye • Rash • Seasonal Flu • Sinus Infection • Sore Throat • Viral Illness • Mental Health	• Anything requiring a hands-on exam • Anything requiring a test • Cancer or other complicated conditions • Chronic Conditions • International Visits • Sprains/Broken bones or injuries requiring bandaging

KRMC Care Anywhere

With KRMC Care Anywhere you can get care for common, easily treatable conditions online with your smartphone (or a desktop computer). Connect with a provider through the convenient web-based platform – without the need for an office visit.

To get care, register at krmc.zipnosis.com, then complete a questionnaire about your condition and symptoms.

A KRMC provider is notified and will review your symptoms. If KRMC Care Anywhere is appropriate for your condition, the provider will send diagnosis and treatment information electronically. If the treatment requires a prescription, the provider will send orders to your pharmacy of choice.

Some conditions require an in-person visit and cannot be diagnosed or treated through KRMC Care Anywhere.

In these cases, the platform will notify you that a more thorough examination is needed, and you will not be charged for a visit.

KRMC Care Anywhere is available from 7:00am – 7:00pm seven days a week. During those operating hours, you can expect a response including a diagnosis and treatment plan within one hour of requesting care.

To see a list of commonly treated conditions – or to get care – visit krmc.zipnosis.com.

Use Virtual Visits for:	Choose Other Care for:
• Allergies • Bladder Infection • Bronchitis • Cough/Cold • Fever • Nausea • Pink Eye • Rash • Seasonal Flu • Sinus Infection • Sore Throat • Viral Illness	• Anything requiring a hands-on exam • Anything requiring a test • Cancer or other complicated conditions • Chronic Conditions • International Visits • Sprains/Broken bones or injuries requiring bandaging

Additional benefits

Summary of Paid Time Off (PTO)**

PTO hours are accrued by full-time employees. Eligible employees begin accruing PTO hours on their first day of employment with KRMC. Employees may not, however, use or receive payment for PTO hours until completion of 90 days of employment. If a hospital-approved holiday occurs before an employee completes 90 days of employment, PTO hours may be advanced to the employee upon department director approval. PTO hours are accrued each pay period according to the number of scheduled hours worked per pay period, up to a maximum of 40 hours, and the number of years of consecutive employment with KRMC. A full-time employee, regularly scheduled for 40 hours per week, may earn 7.07-10.15 hours of PTO time per pay period, depending on their length of service. PTO hours stop accruing when an employee reaches 368 PTO hours.

Use of Benefit: Your PTO hours are available to use for holidays, vacations, personal business, and family need. PTO hours may be used for a personal illness of seven consecutive days or less. Employee must receive supervisor authorization prior to taking time off, unless unforeseeable circumstances make it impossible to do so.

Cash Outs: PTO hours may be cashed out during the approved pay out period or at the employee's termination of employment.

** PTO schedules may differ for different employee classifications. Please see MCN for latest PTO policy.

Employee Perks

All KRMC employees are eligible to receive the employee discounts listed below. These discounts are effective the first day of employment.

KRMC Community Pharmacy: Employees and their dependents are eligible to receive a discount on over-the-counter purchases and the Community Pharmacy. To receive your discount, you must show your ID badge when you make your OTC purchase.

Please refer to pages 6-7 for your Prescription benefit information.

Wellness Center: KRMC employees and their dependents have full access, at a reduced rate, to the wellness center. Employees are also eligible to earn monthly discounts on membership based on usage. One dollar ($1) will be deducted from your membership fee for each usage per month, up to a maximum of $10 off your monthly membership. As an employee, Wellness Center membership must be paid by automatic payroll deduction.

For more information on employee perks such as local and national discounts, please check out the KRMC intranet page.

403(b) retirement savings plan

We're excited to announce that 403(b) Roth contributions will be available KRMC employees in addition to the traditional 403(b) pre-tax option! Roth contributions are funded with after-tax dollars instead of pre-tax dollars. Please note that IRS contribution limits for 2021 are $19,500 and if you are age 50 or older you can contribute an additional catch-up contribution of $6,500 for a total of $26,000. These limits apply to your contributions that are pre-tax, after-tax, or a combination of the two.

Employee contributions	Employer contributions
All KRMC employees are eligible to participate after you receive your first paycheck. You may increase, decrease, or stop your contributions at any time You become eligible for the match once you have completed a year of service. You start to earn matching contributions the first day of the following quarter. Both regular 403(b) pre-tax deferrals and 403(b) Roth post-tax deferrals will be matched at the applicable match level. KRMC makes a quarterly matching contribution, equal or up to 100% of your combined deferrals based on your years of service as outlined to the right.	KRMC will match up to: • 3% after 1 year of employment • 4% after 3 years of employment • 6% after 6 years of employment

Vesting

Vesting refers to your ownership of the money in your 403(b). You are always 100% vested in your contributions to the plan.

457(b) Plan

For certain highly compensated eligible employees, KRMC provides the opportunity to contribute to a 457(b) pretax retirement account. To find out if you are an eligible employee for the 457(b) and to get more information on this savings opportunity, please contact Human Resources.

For questions regarding the investment options, please contact the investment representatives at Financial Management Network (FMN) at 949-455-0300 or you may contact Transamerica directly at 800-755-5801.

More Information

- You can enroll in the plan and make changes to your contributions at any time.
- Transamerica has many different investment options for you to choose from, along with tools and resources you can use to determine which options best meet your investment objectives.

For additional details about the 403(b) Retirement Savings Plan or to enroll or change your contribution rates or investment elections, visit www.azkrmc.trsretaire.com or call 800-755-5801.

Benefit rates

Your bi-weekly (24 pay periods) payroll deductions for medical, dental and vision benefits are shown here.

Medical HDHP $2,800 BCBS of Arizona	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical/Rx Rate	$73.00	$153.00	$114.00	$179.00
Employee Wellness Credit	-$30.00	-$30.00	$-30.00	$-30.00
Spouse Wellness Credit	–	-$15.00	–	$15.00
Employee Non-Tobacco Credit	-$20.00	-$20.00	-$20.00	-$20.00
Spouse Non-Tobacco Credit	–	-$10.00	–	-$10.00
Total Deduction with all Credits	**$23.00**	**$78.00**	**$64.00**	**$104.00**

Medical HDHP $1,400 BCBS of Arizona	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical/Rx Rate	$85.50	$195.50	$149.00	$236.50
Employee Wellness Credit	-$30.00	-$30.00	$-30.00	$-30.00
Spouse Wellness Credit	–	-$15.00	–	$15.00
Employee Non-Tobacco Credit	-$20.00	-$20.00	-$20.00	-$20.00
Spouse Non-Tobacco Credit	–	-$10.00	–	-$10.00
Total Deduction with all Credits	**$35.50**	**$120.50**	**$99.00**	**$161.50**

Medical PPO Plan BCBS of Arizona	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical/Rx Rate	$99.00	$239.00	$183.00	$294.00
Employee Wellness Credit	-$30.00	-$30.00	-$30.00	-$30.00
Spouse Wellness Credit	–	-$15.00	–	$15.00
Employee Non-Tobacco Credit	-$20.00	-$20.00	-$20.00	-$20.00
Spouse Non-Tobacco Credit	–	-$10.00	–	-$10.00
Total Deduction with all Credits	**$49.00**	**$164.00**	**$133.00**	**$219.00**

Delta Dental Plan	DPPO Plan
Employee Only	$7.64
Employee + Spouse	$15.66
Employee + Child(ren)	$14.90
Family	$23.49

If you enroll in the HDHP, KRMC will contribute to a HSA	
Employee Only	$500
Employee + dependent(s)	$1,000

**Please note: the amounts are prorated after July 2021.

VSP Vision Plan	Core Plan	Buy-Up Plan
Employee Only	$0.00	$5.25
Employee + Spouse	$3.11	$10.77
Employee + Child(ren)	$3.33	$11.52
Family	$5.01	$17.34

Glossary

- **Brand preferred drugs** – A drug with a patent and trademark name that is considered "preferred" because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.
- **Brand non-preferred drugs** – A drug with a patent and trademark name. This type of drug is "not preferred" and is usually more expensive than alternative generic and brand preferred drugs.
- **Calendar Year Maximum** – The maximum benefit amount paid each year for each family member enrolled in the dental plan.
- **Coinsurance** – The sharing of cost between you and the plan. For example, 80% coinsurance means the plan covers 80% of the cost of service after a deductible is met. You will be responsible for the remaining 20% of the cost.
- **Copay** – A fixed amount (for example $30) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
- **Deductible** – The amount you have to pay for covered services each year before your health plan begins to pay.
- **Elimination Period** – The time period between the beginning of an injury or illness and receiving benefit payments from the insurer.
- **Flexible Spending Accounts (FSA)** – FSAs allow you to pay for eligible health care and dependent care expenses using tax-free dollars. The money in the account is subject to the "use it or lose it" rule which means you must spend the money in the account before the end of the plan year.
- **Generic drugs** – A drug that offers equivalent uses, doses, strength, quality and performance as a brand-name drug, but is not trademarked.
- **Health Savings Account (HSA)** – An HSA is a personal savings account for those enrolled in a High Deductible Health Plan (HDHP). You may use your HSA to pay for qualified medical expenses such as doctor's office visits, hospital care, prescription drugs, dental care and vision care. You can use the money in your HSA to pay for qualified medical expenses now, or in the future, for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP.
- **High Deductible Health Plan (HDHP)** – A qualified High Deductible Health Plan (HDHP) is defined by the Internal Revenue Service (IRS) as a plan with a minimum annual deductible and a maximum out-of-pocket limit. These minimums and maximums are determined annually and are subject to change.
- **In-network** – A designated list of health care providers (doctors, dentists, etc.) with whom the insurance provider has negotiated special rates. Using in-network providers lowers the cost of services for you and the company.
- **Inpatient** – Services provided to an individual during an overnight hospital stay.
- **Mail Order Pharmacy** – Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.
- **Out-of-network** – Providers that are not in the plan's network and who have not negotiated discounted rates. The cost of services provided by out-of-network providers is much higher for you and the company. Higher deductibles coinsurance will apply.
- **Out-of-pocket maximum** – The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year. Your annual deductible is included in your out-of-pocket maximum.
- **Outpatient** – Services provided to an individual at a hospital facility without an overnight hospital stay.
- **Primary Care Provider (PCP)** – A doctor (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.
- **Reasonable & Customary Charges (R&C)** – Prevailing market rates for services provided by health care professionals within a certain area for certain procedures. Reasonable and Customary rates may apply to out-of-network charges.
- **Specialist** – A provider who has specialized training in a particular branch of medicine (e.g., a surgeon, cardiologist or neurologist).
- **Specialty drugs** – A drug that requires special handling, administration or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.

Contact information

Benefit	Phone	Website/Email
Medical Plans – Blue Cross Blue Shield of Arizona (BCBSAZ) Eligibility, medical benefits, coverage questions, and ID cards	855-818-0237	www.azblue.com
Prescriptions – Express Scripts (ESI) Prescriptions claims, coverage questions KRMC Community Pharmacy – Tier 1 pharmacy coverage	ESI: 877-846-4692 KRMC Community Pharmacy: 928-681-8778	www.express-scripts.com
Medical Review/Precertification – BCBSAZ Medical plan precertification, case management, and medical necessity	855-818-0237	www.azblue.com/individualsandfamilies/resources/forms
Health Savings Account – Health Equity Account balance, covered expenses, and online claims submissions	866-346-5800	www.healthequity.com
Flexible Savings Accounts – Health Equity Account balances, covered expenses, and online reimbursements	866-346-5800	www.healthequity.com
Employee Assistance Program – IBH and ACI Confidential counseling for life's matters	IBH: 800-395-1616 ACI: 855-775-4357	IBH: www.ibhsolutions.com/members ACI: http://rsli.acieap.com
Dental – Delta Dental of Arizona (DDAZ) Dental claims, eligibility, and coverage questions	800-352-6132	www.deltadentalaz.com
Vision – VSP Vision claims, eligibility, and coverage questions	800-877-7195	www.vsp.com
Telemedicine – KRMC Care Anywhere and BlueCare Anywhere Virtual acute care visits	N/A	KRMC Care Anywhere: krmc.zipnosis.com BlueCare Anywhere: www.bluecareanywhereaz.com
Retirement Savings Plans – Transamerica Account balance, account activity, investment options	800-755-5801	azkrmc.trsretire.com
Life – Gallagher Life administration for basic, voluntary life and AD&D	800-583-1571	N/A
Short-Term Disability – KRMC Eligibility, and coverage questions	928-757-0600 Option 1	HumanResourcesBenefits@azkrmc.com
Individual (Buy-Up) Short-Term Disability – UNUM Eligibility, and coverage questions	800-635-5597	www.unum.com
Long-Term Disability – Gallagher Long term disability administration	800-583-1571	N/A
Group Accident and Critical Illness – Reliance Standard Coverage questions and policy information	800-351-7500	N/A
Universal Life – Transamerica Coverage questions and policy information	888-763-7474	N/A

Legal notices

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 their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, **and you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442

ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

Legal notices

CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

KANSAS – Medicaid	NEBRASKA – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

KENTUCKY – Medicaid	NEVADA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

Legal notices

MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

OREGON – Medicaid	VERMONT– Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282

RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

TEXAS – Medicaid	WYOMING – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

Legal notices

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

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

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.

OMB Control Number 1210-0137 (expires 1/31/2023)

Legal notices

MANDATED HEALTH PLAN INFORMATION REQUIRED FOR FEDERAL COMPLIANCE

According to Federal regulations all employers MUST provide information annually pertaining to certain rights covered under health plans.

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to **KRMC** Human Resources Department.

If you have any questions regarding the below information, please contact **HUMAN RESOURCE**S at HumanResourcesBenefits@azkrmc.com or **928-757-0600, Press 1**

Patient Protection Disclosure

The medical plan options offered under **KRMC** Insurance Plan generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact **BCBSAZ** at the number on your ID card.

For children, you may designate a pediatrician as the primary care provider.

HIPAA Special Enrollment Rights

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 or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards 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 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 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 31-day period applies to most special enrollments.

Women's Health and Cancer Rights Act Notices

If you have had or are going to have a mastectomy, you 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.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Legal notices

Notice of Privacy Practices

KRMC (the "Plan") provides health benefits to eligible employees of **KRMC (the "Company")** and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan's Notice of Privacy Practices you should contact **Human Resources**, who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights.

GINA Warning against Providing Genetic Information

The Genetic Information Nondiscrimination Act (GINA) prohibits collection of genetic information by both employers and health plans and defines genetic information very broadly. Asking an individual to provide family medical history is considered collection of genetic information, even if there is no reward for responding (or penalty for failure to respond). In addition, a question about an individual's current health status is considered to be a request for genetic information if it is made in a way likely to result in obtaining genetic information (e.g., family medical history). Wellness programs that require completion of health risk assessments or other forms that request health information may violate the collection prohibition unless they fit within an exception to the prohibition for inadvertent acquisition of such information. This exception applies if the request does not violate any laws, does not ask for genetic information and includes a warning against providing genetic information in any responses.

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Request for Social Security Number

A Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers, third-party administrators (TPAs), and plan administrators or fiduciaries of self-insured/self-administered group health plans (GHPs) to report, as directed by the Secretary of the Department of Health and Human Services, information that the Secretary requires for purposes of coordination of benefits. The law also imposes this same requirement on liability insurers (including self-insurers), no-fault insurers, and workers' compensation laws or plans. Two key elements that are required to be reported are HICNs (or SSNs) and EINs. In order for Medicare to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits, Medicare relies on the collection of both the HICN (or SSN) and the EIN, as applicable.

As a subscriber (or spouse or family member of a subscriber) to a GHP arrangement, **KRMC** will ask for proof of your Medicare program coverage by asking for your Medicare HICN (or your SSN) to meet the requirements of P.L. 110-173 if this information is not already on file with your insurer. Similarly, individuals who receive ongoing reimbursement for medical care through no-fault insurance or workers' compensation or who receive a settlement, judgment, or award from liability insurance (including self-insurance), no-fault insurance, or workers' compensation will be asked to furnish information concerning whether or not they (or the injured party if the settlement, judgment or award is based on an injury to someone else) are Medicare beneficiaries and, if so, to provide their HICNs or SSNs. Employers, insurers, TPAs, etc., will be asked for EINs. To confirm that this ALERT is an official government document and for further information on the mandatory reporting requirements under this law, please visit http://www.cms.gov on the CMS website.

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COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued coverage for a certain period of time at applicable monthly COBRA rates if you, your spouse, or your dependents lose group medical, dental, or vision coverage because you terminate employment (for reason other than gross misconduct); your work hours are reduced below the eligible status for these benefits; you die, divorce, or are legally separated; or a child ceases to be an eligible dependent.

ACA 1557

KRMC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Important Notice from KRMC About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **KRMC** and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. KRMC has determined that the prescription drug coverage offered by the KRMC is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current KRMC coverage will not be affected.

HDHP $2,800
HDHP $1,400
PPO $500

You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current **KRMC** coverage, be aware that you and your dependents may or may not be able to get this coverage back.

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When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with **KRMC** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **KRMC** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage: Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: July 1, 2021
Name of Entity/Sender: KRMC
Contact--Position/Office: Human Resources
Address: 3269 Stockton Hill Rd, Kingman, AZ 86409
Phone Number: (928) 757-2101

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New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment¬-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November each year for coverage starting as early as the immediately following January 1.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% 1 of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.2

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Kingman Regional Medical Center, EIN 94-2916102, 3269 Stockton Hill Rd, Kingman, AZ 86409. You can contact Human Resources at 928.757.0600, Press 1 or email HumanResourcesBenefits@azkrmc.com

As your employer, we offer a health plan to all full-time eligible employees working a minimum of 32 hours per week and we do offer coverage to eligible dependents who are the legal spouse and the legal children, under 26 years of age, of the employee. This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or your work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] As that percentage is adjusted by inflation from time to time.
[2] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

About this Guide

This benefit summary provides selected highlights of the Kingman Regional Medical Center (KRMC) benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Kingman Regional Medical Center (KRMC) reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.