KINGMAN REGIONAL MEDICAL CENTER

2025 – 2026 Benefits Guide

Updated: June 6, 2025

IMPORTANT CONTACTS

COVERAGE	PHONE	WEBSITE
Medical Plans – Blue Cross Blue Shield of Arizona (BCBSAZ) Eligibility, medical benefits, coverage questions and ID cards	855-818-0237	www.azblue.com
Medical Review/Precertification – BCBSAZ Medical plan precertification, case management and medical necessity	855-818-0237	www.azblue.com/individualsandfamilies/resources/forms
Dental – Delta Dental of Arizona (DDAZ) Claims, eligibility and coverage questions	800-352-6132	www.deltadentalaz.com
Vision – VSP Claims, eligibility and coverage questions	800-877-7195	www.vsp.com
Prescriptions – Express Scripts (ESI) Prescriptions claims, coverage questions	877-846-4692	www.express-scripts.com
Prescriptions - KRMC Community Pharmacy Tier 1 pharmacy coverage	928-681-8778	https://fillmyrefills.com/krmc/home
Flexible Savings Account-Health Care – WEX Account balances, expenses and online reimbursement for health care	866-451-3399	https://benefitslogin.wexhealth.com/login
Health Savings Account – WEX Account balance, claims, expenses, and submissions	866-451-3399	https://benefitslogin.wexhealth.com/login
Accident, Critical Illness and Hospital Insurance – Unum Coverage questions and policy information	800-421-0344	www.unum.com
Identity Theft Protection – Norton LifeLock Member Support	800-907-9174	www.norton.com
Individual Short-Term Disability – Unum Eligibility and coverage questions	800-421-0344	www.unum.com
Life – Unum Basic, Voluntary Life and AD&D	800-421-0344	www.unum.com
Long-Term Disability – Unum Administration, eligibility and coverage questions	800-421-0344	www.unum.com
Retirement Savings Plans – Transamerica Account balance, account activity, investment options	800-755-5801	www.transamerica.com
Employee Assistance Program **Unum and Uprise Health** Confidential counseling for life's matters	800-854-1446 800-395-1616	www.unum.com/lifebalance www.uprisehealth.com/members

Your 2025 benefits

At Kingman Healthcare Inc (KHI), we're committed to providing benefits that help you and your family achieve the best possible physical, financial, and emotional wellbeing. We understand the important role that benefits play in the lives of you and your family. We strive to maintain a program that is both comprehensive and competitive and allows you to select plans that meet your individual needs. Whether this is your first time enrolling in benefits or whether you have been through this many times, selecting benefits can be challenging. This guide summarizes the benefit plans available to you and the premiums associated with each plan.

It also contains useful tips, tools and resources to help you make wise decisions. If there are any discrepancies or ambiguities between this guide and any plan provisions, the terms of the Plan Document, Summary Plan Description or insurance policies, contracts and other documents forming the Plan, as interpreted by the Plan Administrator, or any laws or regulations, will apply rather than this guide.

While we are committed to sharing the cost of health care for our employees, you can help keep the costs down by being a responsible health care consumer. This means leading and maintaining a healthy lifestyle, choosing Tier 1 KHI providers if available, evaluating your health care choices when care is needed, and using available resources wisely.

Please read this entire guide for important information about your options. If you have any questions or if you need additional information, please contact any of the appropriate carriers or contact the Benefits Team at 928-757-0600 option 1 or via email at Benefits@azkrmc.org

KHI reserves the right to make changes to plans, administrators and premiums at our discretion.

Eligibility

Regular full-time employees whose scheduled FTE hours are at least 30 per week are eligible to participate in all KHI benefits. Most of your benefits are effective on the first day of the month following your date of hire or qualifying life event. You may also enroll your eligible dependents for coverage. You will be required to submit proof of your relationship to dependents you cover on your insurance, such as a marriage or birth certificate. This includes the following:

- Your legal spouse
- Your own or your spouse's natural, adopted, step-children, or foster children who are under age 26
- Your own or your spouse's children who became disabled before the age of 19 due to a mental or physical disability and who are indicated as such on your federal tax return and in accordance with 42 U.S.C 13282c, may continue to be covered past the age of 26
- Child(ren) placed in your or your spouse's guardianship pending adoption
- Child(ren) under the age of 26 for whom you or your spouse have court-ordered guardianship

If both you and your spouse work for KHI and are eligible for benefits, you may not enroll in dual coverage for any benefits offered. This means that only one of you may cover you and your dependent(s) on insurance.

Changing Benefits After Enrollment

During the year, you cannot make changes to your benefits unless you have a Qualifying Life Event (QLE). You have 31 days from the QLE to make changes to your coverage. Your changes are effective from the first of the month following the date of the QLE. Depending on the type of event, you may need to provide proof of the event, such as a marriage certificate or birth certificate. If you do not make changes within 31 days of the QLE, you will have to wait until the next open enrollment period to make changes (unless you experience another QLE).

Life Event	Documentation Needed
Marriage	Marriage certificate
Divorce/Legal Separation	Divorce Decree or other legal documentation showing removal of benefits
Death	Death Certificate
Birth or Adoption	State issued birth certificate, hospital crib card, or legal adoption papers
Step-child(ren)	Birth certificate plus a copy of the marriage certificate between the employee and spouse
Change in spouse's benefits or employment status	Notification of spouse's employment status or change resulting in a loss or gain coverage
Enrollment in Medicare or Medicaid	Medicare or Medicaid card showing effective date

What happens if you don't enroll each year?

After you first enroll, you are encouraged to review your benefits during open enrollment. If you do not review and re-enroll in benefits during open enrollment, most benefits will rollover year after year, with the exception of the Flexible Spending Account (FSA). You must re-enroll each year to participate. If you have funds you did not use during the current plan year you must enroll in the FSA and elect a minimum of $100.00 to take advantage of those rollover funds.

Medical and Pharmacy

Medical insurance is essential to your well-being and our medical coverage provides you and your family with the protection you need for everyday health issues or when the unexpected happens. KHI offers the choice of four medical plans through BlueCross BlueShield of Arizona (BCBSAZ), which include coverage for prescription drugs through Express Scripts (ESI). To select the plan that best suits you and 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 plan year (July - June).

Medical Plan Options

At KHI, you have the choice of four medical plans, with a range of coverage levels and costs. This gives you the flexibility to choose what fits your needs and budget.

- **PPO $500 or PPO $1,500 plan:** a preferred provider organization plan has a lower deductible than the High Deductible Health Plans, but with higher premium contributions per paycheck.

- **High Deductible Health Plan $1,650 or High Deductible Health Plan $3,200 (HDHP)**: a high-deductible health plan that puts you in charge of your spending through a lower premium contribution, higher deductibles, and access to a tax-free Health Savings Account (HSA).

Making the Most of Your Medical Plan

Getting the most out of your plan depends on how well you understand it. 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.**

Tier 1: KHI Providers: The Tier 1 network consists of providers who work for and in a KHI facility. This network provides you and your family with the most cost-effective option when care is needed.

Tier 2: In-Network Providers: The Tier 2 network are providers who contract with our insurance to provide services to you and your family at a contracted rate.

Tier 3: Out-of-Network Providers: Providers who are not in one of the networks above are considered out-of-network. These types of providers generally cost more because they have not contracted with our insurance to provide services at a reduced rate.

Maximize Your Medical Plan

You may visit any medical provider you choose, but Tier 1 and in-network providers offer the highest level of benefits and lower out-of-pocket costs. In-network providers charge members reduced, contracted fees instead of their typical fees. Providers outside the plan's network set their own rates, so you may be responsible for the difference if a provider's fees are above the Reasonable and Customary (R&C) limits.

High Deductible Health Plans (HDHP)

All In-Network services apply to both Tier 1 and 2 deductibles and out-of-pocket maximums simultaneously. If you meet either the deductible or out-of-pocket maximum, you will cap out at your Tier 1 thresholds first. Services received under Tier 3 only apply towards your Tier 3 deductible and out-of-pocket maximum.

To help cover the cost of the deductible, KHI will contribute a fixed amount each pay period to your HSA account.

- **Employee Only coverage** **$20.83**
- **Family coverage** **$41.67**

The HDHP $3,200 Plan has an embedded deductible and out-of-pocket maximum. Each person only needs to meet the individual deductible before the plan begins paying its share for that individual. Once two or more family members meet the family limits, the plan begins paying its share for all covered family members.

The HDHP $1,600 Plan has a non-embedded deductible and out-of-pocket maximum. 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, it is considered to be met for all of you. Once the family limit is met, the plan will begin paying its share of eligible expenses for the whole family for the rest of the plan year.

	HDHP $3,300			HDHP $1,650		
	TIER 1 KHI Provider	TIER 2 BCBS In-Network Provider	OUT-OF NETWORK	TIER 1 KHI Provider	TIER 2 BCBS In-Network Provider	OUT-OF NETWORK
Plan Year Deductible						
Individual	$3,300	$3,500	$5,400	$1,650	$3,500	$5,400
Family	$6,400	$7,000	$10,800	$3,300	$7,000	$10,800
Plan Year Out-Of-Pocket Maximum (Includes Deductible)						
Individual	$6,000	$6,750	Unlimited	$4,000	$6,750	Unlimited
Family	$12,300	$13,500	Unlimited	$8,000	$13,500	Unlimited
	You Pay			You Pay		
Coinsurance/Copays						
Preventive Care	0%	0%	50%*	0%	0%	50%*
Primary Care Physician	10%*	35%*	50%*	10%*	30%*	50%*
Specialist	10%*	35%*	50%*	10%*	30%*	50%*
Lab / X-Ray / Ultrasound	0%*	35%*	50%*	0%*	30%*	50%*
Advanced Radiology	5%*	35%*	50%*	5%*	30%*	50%*
Urgent Care	10%*	35%*	50%*	10%*	30%*	50%*
Emergency Room	10%*	35%*	35%*	10%*	30%*	30%*
Inpatient Hospital Stay	10%*	35%*	50% & Balance Bill	10%*	30%*	50% & Balance Bill
Outpatient Surgery	10%*	35%*	50%* & Balance Bill	10%*	30%*	50%* & Balance Bill

*After deductible is met

	HDHP $3,300		HDHP $1,650	
	KHI Cost Per Pay Period	Employee Cost Per Pay Period	KHI Cost Per Pay Period	Employee Cost Per Pay Period
Employee Only	$472.54	$39.39	$479.17	$64.35
Employee + Spouse	$916.88	132.62	$923.00	$191.28
Employee + Child(ren)	$811.82	$83.64	$815.66	$135.07
Employee + Family	$1,366.98	$168.75	$1,379.60	$250.94

Preferred Provider Organization (PPO)

A PPO plan allows you to choose from a network of doctors, hospitals, and other providers. All In-Network services apply to both Tier 1 and 2 deductibles and out-of-pocket maximums simultaneously. If you meet either the deductible or out-of-pocket maximum, you will cap out at your Tier 1 thresholds first. Services received under Tier 3 only apply towards your Tier 3 deductible and out-of-pocket maximum.

The PPO Plans have an embedded deductible and out-of-pocket maximum. Each person only needs to meet the individual deductible before the plan begins paying its share for that individual. Once two or more family members meet the family limits, the plan begins paying its share for all covered family members.

	PPO $1,500			PPO $500		
	TIER 1 KHI Provider	TIER 2 BCBS In-Network Provider	OUT-OF NETWORK	TIER 1 KHI Provider	TIER 2 BCBS In-Network Provider	OUT-OF NETWORK
Plan Year Deductible						
Individual	$1,500	$3,500	$7,500	$500	$2,250	$6,750
Family	$3,000	$7,000	$15,000	$1,500	$4,500	$13,500
Plan Year Out-Of-Pocket Maximum (Includes Deductible)						
Individual	$3,000	$7,000	Unlimited	$2,250	$5,000	Unlimited
Family	$7,000	$14,000	Unlimited	$4,500	$15,000	Unlimited
	You Pay			You Pay		
Coinsurance/Copays						
Preventive Care	$0	$0	50%*	$0	$0	50%*
Primary Care Physician	$35 copay	$45 copay	50%*	$30 copay	$45 copay	50%*
Specialist	$45 copay	$55 copay	50%*	$40 copay	$55 copay	50%*
Lab	$10 copay	30%*	50%*	$10 copay	30%*	50%*
X-Ray / Ultrasound	$75 copay	30%*	50%*	$75 copay	30%*	50%*
Advanced Radiology	$375 copay	30%*	50%*	$375 copay	30%*	50%*
Urgent Care	$50 copay	$75 copay	Not covered	$55 copay	$75 copay	Not covered
Emergency Room	$250 copay	$500 copay	$500 copay	$250 copay	$500 copay	$500 copay
Inpatient Hospital Stay	10%*	30%*	50% & Balance Bill	10%*	30%*	50% & Balance Bill
Outpatient Surgery	10%*	30%*	50%* & Balance Bill	10%*	30%*	50%* & Balance Bill

*After deductible is met

	PPO $1,500		PPO $500	
	KHI Cost Per Pay Period	Employee Cost Per Pay Period	KHI Cost Per Pay Period	Employee Cost Per Pay Period
Employee Only	$501.34	$57.92	$488.46	$91.40
Employee + Spouse	$974.41	$172.15	$918.13	$270.64
Employee + Child(ren)	$856.71	$121.56	$818.90	$195.40
Employee + Family	$1,451.92	$225.86	$1,394.27	$345.26

Pharmacy Benefits

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.
- **Mail Order Pharmacy –** If you are prescribed a maintenance medication, there will be a 60-day retail limit. Once you reach that limit, you can only have your prescriptions filled at the KRMC Community Pharmacy or through the Express Scripts Mail Order Pharmacy.

KRMC Community Pharmacy Benefits

Employees who utilize the KHI pharmacy are eligible to fill generic, brand, specialty and 90-day mail order prescriptions at a reduced rate compared to other pharmacies in the area. In addition to lower copays and coinsurance, you will also receive a discount off over-the-counter products when using the KHI pharmacy. You will find cold, allergy, pain, insulin, first aid products and more, that can be purchased using your KHI employee badge.

	HDHP $3,200			HDHP $1,650		
	TIER 1 KHI Pharmacy	TIER 2 ESI In-Network Provider	OUT-OF NETWORK	TIER 1 KHI Provider	TIER 2 BCBS In-Network Provider	OUT-OF NETWORK
Retail Rx (up to 30-day supply)						
Generic	10%*	35%*	Not Covered	10%	30%	Not Covered
Brand Preferred	10%*	35%*	Not Covered	10%	30%	Not Covered
Brand Non-Preferred	10%*	35%*	Not Covered	10%	30%	Not Covered
Specialty	10%*	35%*	Not Covered	10%	30%	Not Covered
Mail Order Rx (up to 90-day supply)						
Generic	10%*	35%*	Not Covered	10%	30%	Not Covered
Brand Preferred	10%*	35%*	Not Covered	10%	30%	Not Covered
Brand Non-Preferred	10%*	35%*	Not Covered	10%	30%	Not Covered

*After deductible is met

	PPO $1,500			PPO $500		
	TIER 1 KHI Pharmacy	TIER 2 ESI In-Network Provider	OUT-OF NETWORK	TIER 1 KHI Provider	TIER 2 BCBS In-Network Provider	OUT-OF NETWORK
Retail Rx (up to 30-day supply)						
Generic	$10	$15	Not Covered	$10	$15	Not Covered
Brand Preferred	$25	$45	Not Covered	$25	$45	Not Covered
Brand Non-Preferred	$45	$60	Not Covered	$45	$60	Not Covered
Specialty	$75	$100	Not Covered	$75	$100	Not Covered
Mail Order Rx (up to 90-day supply)						
Generic	$20	$30	Not Covered	$20	$30	Not Covered
Brand Preferred	$50	$90	Not Covered	$50	$90	Not Covered
Brand Non-Preferred	$90	$120	Not Covered	$90	$120	Not Covered

Health Savings Account vs Flexible Spending Account

Flexible Spending Account (FSA): Allows you to pay for eligible health, dental and vision expenses for you and your dependents using tax-free dollars. Your contribution is deducted from your paycheck on a pretax basis and is put into your FSA account. When you incur expenses, you can access the funds in your account to pay for eligible expenses. FSA's are only available to employees who have enrolled in the PPO $1,500 or PPO $500 plan or who have waived medical coverage.

Health Savings Account (HSA): Allows you to contribute pre-tax dollars into a savings account to pay for eligible health, dental and vision expenses today, tomorrow and even for retirement and your funds in your HSA account grow and earn tax-free interest. One of the best features of an HSA is that any money left in your HSA account at the end of the year rolls over so you can use it next year or sometime in the future. If you leave the company or retire, your HSA goes with you and you can continue to pay for or save for future eligible health care expenses.

The HSA is a bank account and subject to the regulations of the Patriot Act. This means you may be required to verify your identity including your name, date of birth, Social Security Number, and address. If a discrepancy in the data is found in comparison to other independent sources used by WEX (e.g. InstantID), you may be required to submit documentation, such as an electric bill or bank statement, to verify that your information is correct. If you fail to verify your identity, your account will be closed. When that occurs, we will reimburse you for any contributions you made. If you then verify your identity, we will re-open your account and you will then receive contributions on a per pay period basis moving forward. Your funds will not be made retroactive to the beginning of your coverage.

Benefit Type	HSA	FSA
Eligibility	• Must be enrolled in a High Deductible Health Plan • Cannot be enrolled in a traditional Health Care FSA at the same time • Cannot be enrolled in Medicare, including Part A, TriCare, or receiving Social Security benefits • Cannot be claimed as a dependent on another person's tax return	• Cannot be enrolled in a High Deductible Health Plan with a Health Savings Account
Your Contribution (IRS Limits)	**$4,300** for Employee Only coverage **$8,550** for Family coverage **$1,000** additional catch-up contribution for age 55+	**$3,300** for all coverage levels
KHI's Annual Contribution	**$20.83 per pay period** for Employee Only coverage **$41.67 per pay period** for Family coverage	N/A
Roll Over	Yes, if you leave employment or retire	Yes, if you leave employment or retire you may be eligible to roll over your FSA for the plan year to COBRA
Carry Over	Yes, your funds carry over from year to year	Yes, you may carry over up to $640 of unused funds into the next plan year
Contribution Changes	Can change your contributions at any time during the year	During open enrollment only

Note: If you are currently enrolled in the FSA and moving to the HDHP with the HSA, you must exhaust all your FSA funds by 6/30 of the plan year or you will forfeit your remaining balance.

Dental

Taking care of your oral health is not a luxury — it's a necessity to long-term optimal health. With a focus on prevention, early diagnosis and treatment, dental insurance can greatly reduce your costs when it comes to restorative and emergency procedures. You may enroll yourself and your eligible dependents, or you may waive dental coverage. You do not have to be enrolled in medical coverage to elect dental coverage or cover the same dependents under medical and dental. Preventive services are covered at no cost to you and include routine exams and cleanings. You will pay only a small deductible and coinsurance for basic and major services.

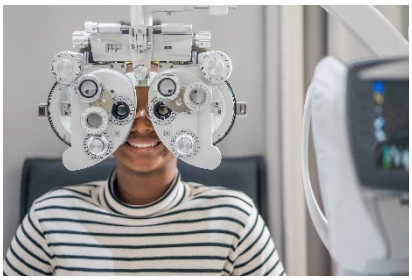
When you visit a dentist in the network, you will maximize your savings. These dentists have agreed to reduced fees, which means you won't get charged more than your expected share of the bill. If you see a Premier or out-of-network dentist, you may incur higher out-of-pocket costs.

	Base Plan	Buy-Up Plan
Covered Services (Combination of in- and out-of-network)		
Plan Year Maximum Benefit	$1,000	$2,000
Plan Year Deductible (Individual/Family)	$25 / $75	$25 / $75
Lifetime Orthodontia Maximum	Not covered	Adult and Child $2,000
Preventive Services		
Exam	$0	$0
Routine Cleanings		
Fluoride: For children up to age 18		
X-rays		
Space Maintainers		
Basic Services		
Sealants: For children up to age 19	15%[1]	15%[1]
Fillings		
Emergency Treatment		
Endodontics: Root canal treatment		
Periodontics: Treat of gum disease		
Oral Surgery: Simple extractions		
Oral Surgery: Surgical extractions		
Major Services		
Prosthodontics: Bridges and partial or complete dentures	40%[1]	40%[1]
Bridge and Denture repair		
Implants		
Restorative: Crowns and onlays		
Orthodontic Services		
Benefits for adults and children age 8 and older	Not covered	50%

	Base Plan		Buy-Up Plan	
	KHI Cost Per Pay Period	Employee Cost Per Pay Period	KHI Cost Per Pay Period	Employee Cost Per Pay Period
Employee Only	$8.93	$5.02	$11.46	$7.64
Employee + Spouse	$17.85	$10.04	$22.54	$15.66
Employee + Child(ren)	$17340	$9.79	$22.35	$14.90
Employee + Family	$26.77	$15.06	$33.81	$23.49

[1] Deductible applies to these services. For a complete listing of covered benefits refer to the benefits plan documents.

Vision



Healthy eyes and clear vision are an important part of your overall health and quality of life. You may enroll yourself and your eligible dependents, or you may waive Vision coverage. You do not have to be enrolled in Medical coverage to elect Vision coverage or cover the same dependents under Medical and Vision.

Note: You will not receive an ID Card for your vision plan. Instead, you will use your Social Security Number when you see a provider.

	Base Plan		Buy-Up Plan	
	You Pay	Reimbursement	You Pay	Reimbursement
Exam	$10 copay	Up to $50	$10 copay	Up to $50
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
Frames	$170 featured frame brands allowance $150 frame allowance (20% discount for balance over allowance)	Up to $70	$220 featured frame brands allowance $200 frame allowance (20% discount for balance over allowance)	Up to $70
Contacts in lieu of Frames/Lenses	$130 allowance; no copay	Up to $60	$150 allowance; no copay	Up to $60
Benefit Frequency				
Exam	Once every 12 months		Once every 12 months	
Lenses*	Once every 24 months		Once every 12 months	
Frames*	Once every 24 months		Once every 12 months	
Contacts*	Once every 24 months		Once every 12 months	

	Base Plan		Buy-Up Plan	
	KHI Cost Per Pay Period	Employee Cost Per Pay Period	KHI Cost Per Pay Period	Employee Cost Per Pay Period
Employee Only	$1.46	$2.00	$1.42	$6.93
Employee + Spouse	$2.67	$3.13	$2.39	$11.66
Employee + Child(ren)	$2.86	$3.36	$2.56	$12.47
Employee + Family	$4.30	$5.05	$3.85	$18.77

* The plan allows for either Contacts or Frames / Lenses every 12 or 24 months, but not both.

Life and AD&D Insurance

Life insurance pays a lump-sum benefit to your beneficiary(ies) to help meet expenses in the event of your death. Accidental Death & Dismemberment (AD&D) insurance pays a benefit if you die or suffer certain serious injuries as the result of a covered accident. In the case of a covered accidental injury (e.g., loss of sight, loss of a limb), the benefit you receive is a percentage of your total AD&D coverage based on the severity of the accidental injury

For all life insurance coverage, benefits will be reduced to 65% at age 70 and 50% at age 75.

Group Life and AD&D Insurance

Coverage Amount	Maximum benefit of $50,000

Voluntary Life and AD&D Insurance – For You and Your Dependents

Coverage Level	**Coverage Amount**	**Evidence of Insurability / Proof of Good Health**
Employee Only	Increments of $10,000 not to exceed 5 times your annual salary or $500,000	Required if electing coverage over $200,000 or if enrolling in coverage for the first time after your initial new hire enrollment opportunity (late entrant)
Spouse	Increments of $5,000 up to $500,000 – not to exceed 100% of employee coverage	Required for amounts greater than $25,000or if enrolling in coverage for the first time after your initial new hire enrollment opportunity (late entrant)
Children	$10,000 per child	None

Guaranteed Issue and Evidence of Insurability

Employees and spouses who elect Voluntary Life and AD&D coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective.

Monthly Rates per $1,000

Age	Employee	Spouse
15 - 24	$0.050	$0.070
25 – 29	$0.060	$0.079
30 – 34	$0.080	$0.093
35 – 39	$0.090	$0.126
40 - 44	$0.130	$0.175
45 – 49	$0.208	$0.275
50 - 54	$0.326	$0.435
55 – 59	$0.494	$0.677
60 – 64	$0.747	$1.194
65 - 69	$1.270	$2.092
70 – 74	$2.258	$3.738

Employee AD&D	$0.025 per $1,000
Spouse AD&D	$0.034 per $1,000
Child Life - $10k	$3.51 per month
Child AD&D - $10k	$3.51 per month

Extended Illness Bank & Individual Short-Term Disability

Sick and Disability Benefits

Sick and Individual Disability Insurance can keep you financially stable should you experience an illness, injury or qualifying disability and become unable to work. It can help provide a sense of security, knowing that if the unexpected should happen, you'll still receive income. A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience.

KHI Extended Illness Bank (EIB)

KHI provides you with EIB benefits if you are unable to work due to your own non-work-related illness or injury. An eligible employee begins accruing EIB hours on their first day of employment and are eligible to use accrued hours following 90 days of employment.

EIB hours are accrued each pay period based on the number of hours worked up to a maximum of 80 paid hours. An employee may accrue up to 4.62 hours each pay period based on actual hours worked, or 15 days per year, up to a maximum of 600 hours. Each EIB hour is equal to **70%** of an employee's base pay (shift differential, specialty pay and overtime do not apply). EIB hours may only be used for a qualifying illness, injury or disability that lasts longer than seven consecutive days. PTO (paid time off) hours must be used for the first week of an illness, injury, or disability, if available and coincide with your regularly scheduled shift.

A signed statement from a health care provider describing the nature of the illness, the necessity to take time off and the expected duration of the disability must be submitted to the Benefits Team in order to use EIB hours, unless you are on FMLA. An employee on approved FMLA is not required to provide a signed statement from a provider. EIB hours have no value except to pay you while you are disabled.

Voluntary Individual Short-Term Disability Insurance (ISTD)

If you become sick or injured and can't work, ISTD 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. A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience.

Choose a monthly benefit between $400 and $3,000 for covered disabilities due to an injury or illness with a 7- or 14-day waiting period. Coverage of up to 60% of your gross monthly salary may be offered. You may have to answer some additional health questions to determine your eligibility.

You may only enroll in the Voluntary Individual Short-Term Disability Insurance (ISTD) during open enrollment.

Long Term Disability (LTD)

You may be eligible to receive Long-Term Disability (LTD) benefits. This program pays you 50% of your normal income, up to a maximum amount, in the event you experience a non-work-related disabling injury or illness. Approved LTD benefits begin after 90 days of disability. The program may pay until you reach age 65 and/or are deemed disabled by Social Security and/or return to work. Further medical documentation may be requested to support the approval process.

Coverage	50% of your pre-disability earnings up to a maximum of $17,500 per month until you recover or reach your Social Security Normal Retirement Age, whichever is sooner.
When Benefits Begin	Benefit begins after 90 calendar days of disability
Election Required	No

Accident Insurance

Accident insurance is a voluntary benefit that pays you a lump sum if you become injured because of an accident. It allows you to claim benefits even if the injuries you incur do not keep you out of work. Accident insurance may also complement health insurance if an accident causes you to have medical expenses that your health insurance doesn't cover.

Accident insurance covers qualifying injuries, which might include a broken limb, loss of a limb, burns, lacerations or paralysis. In the event of your accidental death, Accident insurance pays out money to your designated beneficiary. While health insurance companies pay your provider or facility, Accident insurance pays you directly.

Accident insurance does not apply when you experience a work-related injury.

How does Accident Insurance Work?

Accident insurance policies can provide you with a lump sum paid directly to you that will help pay for a wide range of situations, including initial care, surgery, transportation and lodging and follow-up care. Here's how it works:

- A set amount between $25 and $25,000 dollars, is payable based on the injury you suffer and the treatment you receive.
- Benefits are payable directly to you (unless you specify otherwise) and can be used as you see fit.
- Coverage is available for you, your spouse and eligible dependent children.
- You do not need to answer medical questions or have a physical exam to get basic coverage.
- Accident insurance covers injuries that happen on the job or off the job — unlike workers' compensation, which only covers on-the-job injuries.
- Benefit payments are not reduced by any other insurance you may have with other companies.
- Each covered member is eligible for one $75 wellness benefit every 12 months.

The following is an example of the benefit amount you may be eligible to receive if you are injured because of an accident:

Type of Injury	Typical Amount
Ambulance Reimbursement	$200 - $800
Burns	$375 - $7,500
Concussion	$200
Durable Medical Equipment	$35 - $150
Emergency Dental	$75 - $300
Emergency Room Visit	$75
Hospital Admission – ICU	$800
Physician / Urgent Care	$25
Shoulder Dislocation	$125 - $2,625
X-Rays	$50 - $100

	Employee Cost Per Pay Period
Employee Only	$4.24
Employee + Spouse	$7.91
Employee + Child(ren)	$10.33
Employee + Family	$14.00

Critical Illness Insurance

Critical Illness insurance pays you when are unexpectedly diagnosed with a critical illness such as heart attack, cancer, stroke, major organ failure or a progressive disease such as dementia or multiple sclerosis.

You have three benefit options to choose from including $10k, $20k or $30k for each illness. When you sign up for employee only coverage, your children up to age 26 will automatically be covered at no additional charge. In addition to the critical illness you are eligible for, your children are also covered under your policy for specific childhood conditions such as Cerebral palsy, cleft palate, Down syndrome and spina bifida. In all cases, the diagnosis must occur after the coverage effective date. You are also eligible to enroll your spouse in the same level of coverage you choose for yourself.

Each covered member is eligible for one of the following benefits every 12 months.
- Critical Illness coverage of $10,000 = $50 Be Well benefit
- Critical Illness coverage of $20,000 = $75 Be Well benefit
- Critical Illness coverage of $30,000 = $100 Be Well benefit

How will a Critical Illness Claim Get Paid?

After purchasing Critical Illness insurance, if you suffer from one of the serious illnesses covered by your policy, you'll be paid a lump sum. The payment will go directly to you instead of to a medical provider. The payment you receive can be used for many things including:
- Childcare costs
- Medical expenses
- Travel expenses for you and your family
- Lost wages from missed time at work
- Living expenses

Critical Illness Premiums

Premiums for the Critical Illness plan will be calculated when you enroll in coverage through Oracle.

Hospital Insurance

Hospital Indemnity insurance is a plan designed to pay for the costs of a hospital admission that may not be covered by other insurance. The plan provides benefits if you are admitted to a hospital or ICU for a covered sickness or injury. Even if your medical insurance covers most of your hospitalization, you can still receive payments from your Hospital Indemnity insurance plan to cover extra expenses while you recover.

The plan pays you $500 if you are admitted to the hospital and $100 per day up to 365 days. The plan pays you $1,000 if you are admitted to the ICU and $200 per day up to 30 days.

How does Hospital Indemnity Insurance Work?

You pay monthly premiums for your Hospital Indemnity insurance plan. If you are admitted to the hospital for an injury or illness, your Hospital Indemnity plan makes cash payments to you. The payments go directly to you to use as emergency funds and can be used to cover medical insurance premiums, deductibles, copays and coinsurance, childcare expenses while you are in the hospital, or cost-of-living expenses as you recover.

Note: The plan covers one hospital and one ICU admission per calendar year per covered member. There is no pre-existing limitation for childbirth.

Type	Benefit	Amount
Hospital Admission	Payable for a maximum of one day per year	$500
Hospital Daily Stay	Payable for a maximum of 364 days per year	$100
ICU Admission	Payable for a maximum of one day per year	$1,000
ICU Daily Stay	Payable for a maximum of 30 days per year	$200

	Employee Cost Per Pay Period
Employee Only	$4.97
Employee + Spouse	$9.78
Employee + Child(ren)	$8.52
Employee + Family	$13.32

Norton LifeLock

Get the all-in-one protection for your identity and devices with the Benefit Essential Plan from Norton LifeLock. LifeLock looks for uses of your personal information and with proprietary technology, alerts you to a wide range of potential threats to your identity.

- ✓ **Norton Device Security** protects against existing and emerging threats, including ransomware, viruses, spyware, malware and other online threats
- ✓ **Parental Control** helps keep your kids safer online. Help your kids explore the Web more safely by keeping you informed of sites they are visiting and blocking harmful or inappropriate ones.
- ✓ **Privacy Monitor** scans common public people-search websites for your personal information and helps you opt out, giving you peace of mind and greater control over your online privacy.

Benefit Essential Plan Features

- Identity Lock
- Credit, Bank & Utility Account Freezes
- LifeLock Identity Alert System
  - Identity Verification Monitoring
  - Telecom/Cable Application for New Service
  - Payday - Online Lending Alerts
  - Credit Alerts & Social Security Alerts
- LifeLock Identity mobile app for Android/iOS
- Dark Web Monitoring including Gamer Tags and Password Combo List
- USPS Address Change Verification
- Stolen Wallet Protection
- Reduced Pre-Approved Credit Card Offers
- Fictitious Identity Monitoring
- Data Breach Notifications
- Bank & Credit Card Activity Alerts & Recurring Charge Alert
- 401(k) & Investment Account Activity Alerts
- File Sharing Network Searches
- Sex Offender Registry Reports
- Prior Identity Theft Remediation
- U.S.-based Identity Restoration Specialists
- 24/7 Live Member Support
- Million Dollar Protection™ Package – including Stolen Funds Reimbursement, Personal Expense Compensation, and Coverage for Lawyers and Experts up to $1 million each
- Credit Application Alerts and Monitoring for One-Bureau

Norton Device Security

- Secures PCs, Mac & Mobile Devices – up to 3 devices
- Online Threat Protection
- Password Manager
- Parental Control
- Smart Firewall
- 10GB Cloud Backup
- Online Privacy Monitor

	Benefit Essential Plan		Benefit Premier* Plan	
	KHI Cost Per Pay Period	Employee Cost Per Pay Period	KHI Cost Per Pay Period	Employee Cost Per Pay Period
Employee Only	$0.88	$0.87	$1.75	$3.25
Employee + Family	$1.75	$3.25	$1.75	$8.25

*** Premier includes all of the Essential Plan Features as well as Home Title Monitoring, Credit Score Tracking, 5 devices and more.**

Retirement Savings Plan

What does retirement look like for you? Maybe you plan to travel the world or maybe you'd like to take up some hobbies closer to home. Whatever your goal, it's important to take responsibility for your own finances so you have the income you'll need in the future.

One of the best ways to ensure a secure retirement is to start saving as early as possible. Our 403(b) savings plan allows you to save for retirement on a pretax basis or with after-tax dollars through a Roth plan. After you receive your first paycheck, you can set up your account to start making contributions through convenient payroll deductions. The 2025 contribution limit is $23,500.

To establish or access an existing account, login to the Transamerica portal at: www.transamerica.com/portal

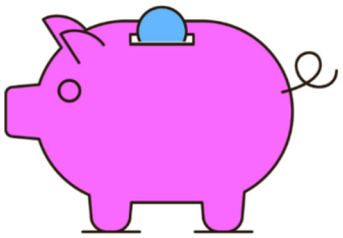
403(b)

- All KHI employees are eligible to participate after receiving your first paycheck.
- The matching deposit is made after the end of each quarter. The match takes into consideration only the amount you contributed during the quarter based on quarterly wages. To get the maximum match, you should consider contributing a fixed percentage of your wages every pay period.
- You become eligible for the match once you have completed one year of service. You start to earn matching contributions the first day of the following quarter.
- KHI makes a quarterly matching contribution, equal or up to 100% of your combined deferrals based on your years of service as outlined below. KHI will match your contribution for each dollar you contribute to the plan:
  - Up to 3% between 1 and the end of your 3rd year of employment
  - Up to 4% between 4 and the end of your 5th year of employment
  - Up to 6% after 6 years of employment
  - You are 100% vested in your and KHI's contributions
- Change the amount of your contributions or stop your payroll contributions at any time.
- All use of PTO, including PTO payouts during the year or at termination, will include deferrals into your account.
- Age 50 or older? Make an additional "catch-up" contribution of up to $7,500 to save even more.
- Age 60 – 63? If you are at least age 60 but not over age 63 during the calendar year, the catch-up contribution limit is increased to $11,250.

457(b)

For physicians and executive personnel, KHI provides the opportunity for you to contribute to a 457(b) pretax retirement account. For additional information on this pretax savings opportunity, please contact the Benefits Team at **Benefits@azkrmc.org** or by calling 928-757-0600 option 1.

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.



Employee Assistance Program (EAP)

You automatically have access to the Employee Assistance Program (EAP) through Uprise Health, Unum, or both. The EAP provides professional, confidential telephonic or face-to-face counseling services to you and your household members at no cost.

The EAP can help you resolve personal issues and problems before they affect your health, relationships and work performance. It's important to note that all EAP conversations are voluntary and strictly confidential. If you and your counselor determine that additional assistance is needed, you'll be referred to the most appropriate and affordable resource available. Although you're responsible for the cost of referrals, these costs are often covered under your Medical plan.

This program is available 24 hours a day, 365 days a year for confidential counseling, referral and follow-up services for issues such as:

- Stress
- Marital or family problems
- Anxiety and depression
- Substance abuse (alcohol and/or drugs)
- Financial issues
- Aging parents
- Pet care
- Maintenance and repair providers
- Community volunteer opportunities
- Childcare issues – including identifying schools, day care, tutors and more

Uprise Health EAP Program
5 free sessions per issue per year
Toll free (800) 395-1616
https://members.uprisehealth.com/
Access Code: KRMC

Unum EAP Program
3 free sessions per issue per year
Toll free (800) 854-1446 (multi-lingual)
www.unum.com/lifebalance

Education Reimbursement Programs

There are several opportunities for employees to further their education and career including Tuition Reimbursement, Scholarship, Certifications, and Loan Repayment Programs.

An employee may only participate in one program at a time. This means that an employee may not seek reimbursement for the same course under the Tuition Reimbursement, Scholarship, or Certification Programs or if an employee also receives a grant from an institution, organization or other source for that course. A course may only be submitted for reimbursement one time.

Tuition Reimbursement and Job-Related Certifications

- Allows for reimbursement of educational expenses to further education in a healthcare-related field. An employee must have worked for KHI for a minimum of 90 days prior to being eligible and must remain in good during the previous 12 months. The calendar year limit is $5,250 and an employee must commit to working for KHI for a minimum of 1 year.
    - For more details, contact: Tuition@azkrmc.org

Scholarships

- The KHI Foundation offers scholarships to employees seeking financial assistance while pursuing their 1st degree in a healthcare-related field. An employee must have worked for KHI for a minimum of 90 days prior to being eligible and must remain in good during the previous 12 months. The calendar year limit is $5,250 for a total reimbursement not to exceed $10,000 and an employee must commit to working for KHI for a minimum of 3 years.
    - For more details, contact: Tuition@azkrmc.org

Chamberlain Grant – Advancing Care Together (ACT)

- A Registered Nurse may apply for a grant to purse a bachelor's degree in nursing.
    - For more details, contact: Chandra.Johnson@azkrmc.org

The following loan repayment programs may be available depending on your location and specialty.

- National Health Service Corps
- National Health Service Corps Substance Use Disorder
- National Health Service Corps Rural Community
- Nurse Corps
- Substance Use Disorder Treatment and Recovery
- Arizona Primary Care Provider
    - For more details, contact HPSA Acumen Benefit Support
    - support@hpsa.us or (716) 483-0888

Public Service Loan Forgiveness (PSLF)

If you're employed by a government or not-for-profit organization, you might be eligible for the PSLF Program. The PSLF Program forgives the remaining balance on your Direct Loans after you've made the equivalent of 120 qualifying monthly payments under an accepted repayment plan, and while working full-time for an eligible employer.

Visit www.studentaid.gov or https://studentaid.gov/manage-loans/forgiveness-cancellation/public-service for additional information on this program.

Glossary

The following insurance terms and definitions will help you better understand your coverages and use your benefits wisely through the year.

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.

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.

Embedded – For family coverage, each person only needs to meet the individual deductible before the plan begins paying its share for that individual. Once two or more family members meet the family limit, the plan begins paying its share for all covered family members.

Non-Embedded – For family coverage, there is only one limit that applies to everyone. When a combination of family members has expenses that meet the family deductible, it is considered met for all members. Once the family limit is met, the plan will begin its share of eligible expenses for the whole family for the rest of the year.

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 health care 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 health care 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. You cannot be enrolled in Medicare, Social Security or Tricare if you are participating in an HSA.

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 Provider – Health care providers (doctors, dentists, etc.) with whom the insurance carrier has negotiated special rates. Using in-network providers lowers the cost of services for you and KHI.

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 Provider – Those 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 and 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.

Embedded – For family coverage, each person only needs to meet the individual out-of-pocket maximum before the plan pays benefits at 100% of eligible expenses. Once two or more family members meet the family out-of-pocket limit, the plan pays benefits at 100% of eligible expenses.

Non-Embedded – For family coverage, there is only one out-of-pocket maximum that applies to everyone. When a combination of family members has expenses that meet the family out-of-pocket maximum, it is considered met for all members. Once the family limit is met, the plan pays benefits at 100% of eligible expenses for the remainder of the year.

Outpatient – Services provided to an individual at a hospital facility without an overnight hospital stay.

Plan Year – The plan year is July 1 through June 30.

Preferred Provider Organization (PPO) – A network of health care providers contracted to provide medical services to covered employees and dependents at negotiated rates. You may seek care from either an in-network or out-of-network provider, but in-network care is covered at a higher benefit level. You will be responsible for a greater portion of the cost when using an out-of-network provider.

Primary Care Physician (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.

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.

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 the KHI Benefits Team.

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

Patient Protection Disclosure
The medical plan options offered under KHI Insurance Plan generally allows 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 30 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 30-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.

Notice of Privacy Practices
KHI (the "Plan") provides health benefits to eligible employees of KHI (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 the Benefits Team, 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 that provide maternity or newborn infant coverage must include in their SPDs a statement describing (a) any requirements under federal or state law applicable to the plan (or to any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child; and (b) any coverage offered under the plan relating to such a hospital stay. A plan subject to the Newborns' and Mothers' Health Protection Act (NMHPA) must include in its SPD a description of NMHPA's requirements for hospital stays for newborns and mothers following childbirth. The above link provides sample language (located on page 140).

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, KHI 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.

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
KHI 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 KHI 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 [Insert Name of Entity] 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. [Insert Name of Entity] has determined that the prescription drug coverage offered by the [Insert Name of Plan] 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 BCBSAZ coverage will not be affected.

HDHP $3,300
HDHP $1,650
PPO $1,500
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 KHI coverage, be aware that you and your dependents may or may not be able to get this coverage back.

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 KHI 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 KHI 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: 7/1/2025
Name of Entity/Sender: KHI
Contact--Position/Office: Benefits Team
Address: 3269 Stockton Hill Rd, Kingman, AZ 86409 Phone Number: 928-757-2101 CMS Form 10182-CC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information
Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

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 is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[12]

When Can I Enroll in Health Insurance Coverage through the Marketplace?
You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?
If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP

coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?
For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

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The Marketplace can help you evaluate your coverage options, 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] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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 March 17, 2025. Contact your State for more information on eligibility.

ALABAMA – MEDICAID
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – MEDICAID
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – MEDICAID
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – MEDICAID
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 / State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – MEDICAID
Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – MEDICAID
GA HIPP Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third- party-liability/childrens-health-insurance-program-reauthorization-act- 2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – MEDICAID
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – MEDICAID AND CHIP (HAWKI)
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
KANSAS – MEDICAID
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – MEDICAID
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/ kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – MEDICAID
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – MEDICAID
Enrollment Website: https://www.mymaineconnection.gov/benefits/ s/?language=en_US Phone: 1-800-442-6003 / TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 / TTY: Maine relay 711
MASSACHUSETTS – MEDICAID AND CHIP
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 / TTY: 617-886-8102 Email: masspremassistance@accenture.com
MINNESOTA – MEDICAID
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3739
MISSOURI – MEDICAID
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005
MONTANA – MEDICAID
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – MEDICAID
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – MEDICAID
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – MEDICAID
Website: https://www.dhhs.nh.gov/programs-services/medicaid/ health-insurance-premium-program Phone: 603-271-5218 Toll-free Number for the HIPP Program: 1-800-852-3345, ext. 5218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – MEDICAID AND CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/ clients/medicaid/ Medicaid Phone: 800-356-1561 CHIP Premium Assistance Phone 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – MEDICAID
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – MEDICAID
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – MEDICAID
Website: hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – MEDICAID AND CHIP

Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – MEDICAID
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – MEDICAID AND CHIP
Website: ://www.pa.gov/en/services/dhs/apply-formedicaid-health-insurance-premium-payment-programhipp.html Phone: 1-800-692-7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – MEDICAID AND CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – MEDICAID
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – MEDICAID
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – MEDICAID
Websitehttps://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493
UTAH – MEDICAID AND CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – MEDICAID
Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427
VIRGINIA – MEDICAID AND CHIP
Website: https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – MEDICAID
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – MEDICAID AND CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – MEDICAID AND CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – MEDICAID
Website: https://health.wyo.gov/healthcarefin/medicaid/programs- and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, 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 1/31/2026)