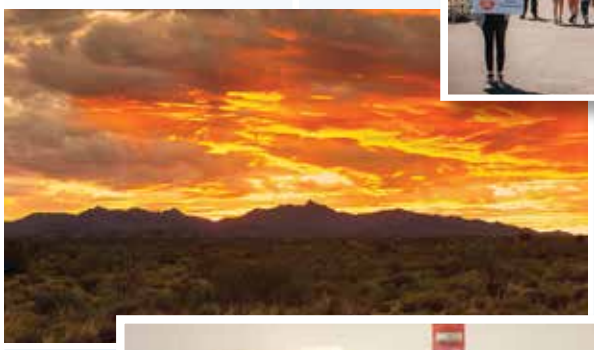
KINGMAN REGIONAL MEDICAL CENTER



2023–2024

Employee Benefits Guide

LIVE YOUR BEST LIFE

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
Prescriptions – Express Scripts (ESI) Prescriptions claims, coverage questions	877-846-4692	www.express-scripts.com
KRMC Community Pharmacy – Tier 1 pharmacy coverage	928-681-8778	N/A
Medical Review/Precertification – BCBSAZ Medical plan precertification, case management, and medical necessity	855-818-0237	www.azblue.com/individualsandfamilies/resources/forms
Telemedicine – BlueCare Anywhere and Same-Day Sick Virtual Visits Virtual acute care visits	N/A	krmc.zipnosis.com www.bluecareanywhereaz.com
Group Accident, Critical Illness and Hospital Insurance - Unum Coverage questions and policy information	800-421-0344	www.unum.com
Health Savings Account - Health Equity Account balance, covered expenses, and online claims submissions	866-346-5800	www.healthequity.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
Flexible Savings Accounts – Health Equity Account balances, covered expenses, and online reimbursements for health care and dependent care	866-346-5800	www.healthequity.com
Life – Unum Life administration for Basic, Voluntary Life and AD&D	800-421-0344	www.unum.com
Extended Illness Bank – KHI Eligibility, and coverage questions	928-757-0600 Option 1	Benefits@azkrmc.com
Individual Short-Term Disability – Unum Administration, eligibility, and coverage questions	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	www.unum.com/lifebalance
	800-395-1616	www.uprisehealth.com/members
Identity Theft Protection – Norton LifeLock Member Support	800-607-9174	www.norton.com

Table of Contents

Your Benefits

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, 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 healthcare 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 on page 2 or contact the Benefits Team at 928-757-0600 option 1 or via email at **Benefits@azkrmc.com**.

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

ELIGIBILITY

If you work at least 36 hours per week, you are eligible for 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, or step-child(ren) who are under age 26 or became disabled before the age of 19
- Child(ren) placed in your or your spouse's guardianship pending adoption
- You or your spouse's foster child(ren) under the age of 26
- Child(ren) under the age of 26 for whom you or your spouse have court-ordered guardianship

Please Note: If your dependent child(ren) are disabled, you must file an application for continuation of dependent status within 31 days of the child(ren) turning age 19. You need to provide verification that your dependent child has a qualifying permanent disability that occurred prior to age 19, in accordance with 42 U.S.C. 1382c.

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.

	Documentation Needed
Marriage	Copy of marriage certificate
Divorce/Legal Separation	Copy of divorce decree
Death	Copy of death certificate
Birth or adoption	Copy of state issued birth certificate, hospital crib card, or copy of legal adoption papers
Step-child(ren)	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
Death	Copy of death certificate
Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage
Enrollment in Medicare or Medicaid	Copy of Medicare or Medicaid card

Changing Benefits After Enrollment

During the year, you cannot make changes to your benefits unless you have a Qualifying Life Event. You have 31 days from the Qualifying 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 or birth certificate. If you do not make changes within 31 days of the Qualifying Life Event, you will have to wait until the next open enrollment period to make changes (unless you experience another Qualifying Life Event).

MEDICAL AND PHARMACY

Medical insurance is essential to your well-being and our medical coverage provides you and your family 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, 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 year.

Parts of Your Medical Plan

- **Annual Deductible Amounts** – The amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay.
- **Annual Out-of-Pocket Maximums** – The most you will pay each year for eligible in-network and out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan picks up the full cost of covered medical care for the remainder of the year.
- **Copays** – A copay is a fixed amount you pay for a health care service. Copays do not count toward your deductible but do count toward your annual out-of-pocket maximum.
- **Coinsurance** – Once you've met your deductible, you and the plan share the cost of care, called coinsurance.
- **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.
- **Plan Year** – The plan year is July–June.
- **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 a network or non-network provider, but network care is covered at a higher benefit level and you will be responsible for a greater portion of the cost when using a non-network provider.

Making the Most of Your 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.

HDHP $3,000

The HDHP $3,000 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.

Services received under Tier 1 apply towards the deductible and out-of-pocket maximums for Tier 2. Tier 2 applies towards the deductible and out-of-pocket maximum for Tier 1. 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. Please see page 15 for additional information.

HSA Employer Contribution for Employee Only Coverage - $20.83
HSA Employer Contribution for Family Coverage - $41.66

	HDHP $3,000 (Embedded)		
	TIER 1 KHI PROVIDER	TIER 2 BCBS IN-NETWORK PROVIDER	OUT-OF-NETWORK
	You Pay		
Plan Year Deductible			
Individual	$3,000	$3,500	$5,400
Family	$6,000	$7,000	$10,800
Plan Year Out-of-Pocket Maximum (Includes Deductible)			
Individual	$6,000	$6,750	Unlimited
Family	$12,000	$13,500	
Coinsurance			
Preventive Care	0%	0%	50%*
Primary Care Physician	10%*	35%*	50%*
Lab	0%*	35%*	50%*
Imaging	5%*	35%*	50%*
Specialist	10%*	35%*	50%*
Urgent Care	10%*	35%*	50%*
Emergency Room	10%*	35%*	35%*
Telehealth	10%*	35%*	Not covered
Behavioral Health Inpatient / Outpatient	Not available	35%*	50%*
Employee Cost Per Pay Period			
Employee Only	$36.06		
Employee + Spouse	$121.44		
Employee + Child(ren)	$76.59		
Employee + Family	$154.53		

* After deductible is met

HDHP $1,500

The HDHP $1,500 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 year.

Services received under Tier 1 apply towards the deductible and out-of-pocket maximums for Tier 2. Tier 2 applies towards the deductible and out-of-pocket maximum for Tier 1. 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. Please see page 15 for additional information.

HSA Employer Contribution for Employee Only Coverage - $20.83
HSA Employer Contribution for Family Coverage - $41.66

	HDHP $1,500 (Non-Embedded)		
	TIER 1 KHI PROVIDER	TIER 2 BCBS IN-NETWORK PROVIDER	OUT-OF-NETWORK
	You Pay		
Plan Year Deductible			
Individual	$1,500	$3,500	$5,400
Family	$3,000	$7,000	$10,800
Plan Year Out-of-Pocket Maximum (Includes Deductible)			
Individual	$4,000	$6,750	Unlimited
Family	$8,000	$13,500	
Coinsurance			
Preventive Care	0%	0%	50%*
Primary Care Physician	10%*	30%*	50%*
Lab	0%*	30%*	50%*
Imaging	5%*	30%*	50%*
Specialist	10%*	30%*	50%*
Urgent Care	10%*	30%*	50%*
Emergency Room	10%*	30%*	30%*
Telehealth	10%*	30%*	Not covered
Behavioral Health Inpatient / Outpatient	Not available	30%*	50%*
Employee Cost Per Pay Period			
Employee Only	$58.92		
Employee + Spouse	$175.16		
Employee + Child(ren)	$123.68		
Employee + Family	$229.80		

* After deductible is met

PPO $1,500

The PPO $1,500 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.

Services received under Tier 1 apply towards the deductible and out-of-pocket maximums for Tier 2. Tier 2 applies towards the deductible and out-of-pocket maximum for Tier 1. Services received under Tier 3 only apply towards your Tier 3 deductible and out-of-pocket maximum.

	PPO $1,500 (Embedded)		
	TIER 1 KHI PROVIDER	TIER 2 BCBS IN-NETWORK PROVIDER	OUT-OF-NETWORK
	You Pay		
Plan Year Deductible			
Individual	$1,500	$3,500	$7,500
Family	$3,000	$7,000	$15,000
Plan Year Out-of-Pocket Maximum (Includes Deductible)			
Individual	$3,000	$7,000	Unlimited
Family	$7,000	$14,000	
Coinsurance / Copays			
Preventive Care	$0	$0	50%*
Primary Care Physician	$35 copay	$45 copay	50%*
Lab	$10 copay	30%*	50%*
X-Ray	$75 copay	30%*	50%*
Advanced Radiology	$375 copay	30%*	50%*
Specialist	$45 copay	$55 copay	50%*
Urgent Care	$50 copay ded. does not apply	$75 copay ded. does not apply	Not covered
Emergency Room	$150 copay ded. does not apply	$300 copay ded. does not apply	$300 copay ded. does not apply
Telehealth Medical Counseling & Psychiatric	 $10 copay $35 copay	 $10 copay $35 copay	 Not covered Not covered
Behavioral Health Inpatient Outpatient	Not available	 10%* $45 copay (PCP) or 10%*	 50%* 50%*
Employee Cost Per Pay Period			
Employee Only	$53.03		
Employee + Spouse	$157.64		
Employee + Child(ren)	$111.32		
Employee + Family	$206.82		

* After deductible is met

PPO $500

The PPO $500 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.

Services received under Tier 1 apply towards the deductible and out-of-pocket maximums for Tier 2. Tier 2 applies towards the deductible and out-of-pocket maximum for Tier 1. Services received under Tier 3 only apply towards your Tier 3 deductible and out-of-pocket maximum.

	PPO $500 (Embedded)		
	TIER 1 KHI PROVIDER	TIER 2 BCBS IN-NETWORK PROVIDER	OUT-OF-NETWORK
	You Pay		
Plan Year Deductible			
Individual	$500	$2,250	$6,750
Family	$1,500	$4,500	$13,500
Plan Year Out-of-Pocket Maximum (Includes Deductible)			
Individual	$2,250	$5,000	Unlimited
Family	$4,500	$15,000	
Coinsurance / Copays			
Preventive Care	$0	$0	50%*
Primary Care Physician	$30 copay	$45 copay	50%*
Lab	$10 copay	30%*	50%*
X-Ray	$75 copay	30%*	50%*
Advanced Radiology	$375 copay	30%*	50%*
Specialist	$40 copay	$55 copay	50%*
Urgent Care	$50 copay ded. does not apply	$75 copay ded. does not apply	Not covered
Emergency Room	$150 copay ded. does not apply	$300 copay ded. does not apply	$300 copay ded. does not apply
Telehealth Medical Counseling & Psychiatric	 $10 copay $30 copay	 $10 copay $30 copay	 Not covered Not covered
Behavioral Health Inpatient Outpatient	Not available	 10%* $45 copay (PCP) or 10%*	 50%* 50%*
Employee Cost Per Pay Period			
Employee Only	$83.69		
Employee + Spouse	$247.84		
Employee + Child(ren)	$178.93		
Employee + Family	$316.17		

* After deductible is met

Pharmacy Benefits - Express Scripts (ESI)

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 take a maintenance medication on an ongoing basis for a condition like high cholesterol or high blood pressure, you must use the Mail Order Pharmacy or KHI Pharmacy. Mail order prescriptions will save you money on a 90-day supply.

KHI 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.

If you are prescribed a maintenance medication, there is a retail limit of 60 days. Once you reach that limit, you can only have your prescription filled at the KHI Pharmacy or through the Mail Order Pharmacy.

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 $3,000 - Express Scripts (ESI)			
	TIER 1 KHI PHARMACY	TIER 2 ESI IN-NETWORK PHARMACY	OUT-OF-NETWORK
Retail RX (up to 30-day supply)			
Generic	10%*	35%*	Not covered
Brand Preferred	10%*	35%*	
Brand Non-Preferred	10%*	35%*	
Specialty	10%*	35%*	
Mail Order RX (up to 90-day supply)			
Generic	10%*	35%*	Not covered
Brand Preferred	10%*	35%*	
Brand Non-Preferred	10%*	35%*	

HDHP $1,500 - Express Scripts (ESI)			
	TIER 1 KHI PHARMACY	TIER 2 ESI IN-NETWORK PHARMACY	OUT-OF-NETWORK
Retail RX (up to 30-day supply)			
Generic	10%*	30%*	Not covered
Brand Preferred	10%*	30%*	
Brand Non-Preferred	10%*	30%*	
Specialty	10%*	30%*	
Mail Order RX (up to 90-day supply)			
Generic	10%*	30%*	Not covered
Brand Preferred	10%*	30%*	
Brand Non-Preferred	10%*	30%*	

PPO $1,500 - Express Scripts (ESI)			
	TIER 1 KHI PHARMACY	TIER 2 ESI IN-NETWORK PHARMACY	OUT-OF-NETWORK
Retail RX (up to 30-day supply)			
Generic	$10	$15	Not Covered
Brand Preferred	$25	$45	
Brand Non-Preferred	$45	$60	
Specialty	$75	$100	
Mail Order RX (up to 90-day supply)			
Generic	$20	$30	Not covered
Brand Preferred	$50	$90	
Brand Non-Preferred	$90	$120	

PPO $500 - Express Scripts (ESI)			
	TIER 1 KHI PHARMACY	TIER 2 ESI IN-NETWORK PHARMACY	OUT-OF-NETWORK
Retail RX (up to 30-day supply)			
Generic	$10	$15	Not Covered
Brand Preferred	$25	$45	
Brand Non-Preferred	$45	$60	
Specialty	$75	$100	
Mail Order RX (up to 90-day supply)			
Generic	$20	$30	Not covered
Brand Preferred	$50	$90	
Brand Non-Preferred	$90	$120	

TELEMEDICINE

When you need care — anytime, day or night — or when your primary care provider is not available, telemedicine can be a convenient option. With telemedicine, you don't have to drive to the provider's office or sit in a waiting room when you're sick — you can see your provider from the comfort of your own bed or sofa.

Avoid germs in the ER, urgent care clinic or provider's office.

See a board-certified, licensed, telehealth-trained provider on your schedule with on-demand virtual visits 24/7, including nights, weekends and holidays.

Get treated for more than 80 common conditions including colds, flu, allergies and more.

Get a prescription or short-term refill of any existing prescription sent to a pharmacy nearby, in less time than your usual provider visit.

Avoid costly copays and deductibles of the ER and urgent care clinic.

Register Today so You Are Ready When You Need Care

Providers are ready to help you get the care you need, anywhere and anytime.

STEP 1

Register Now

Setting up your secure account takes only minutes.

Visit:
www.BlueCareAnywhereAZ.com

Or:
My KRMC Health Portal

STEP 2

Request a Visit

You can meet with a provider right away or schedule an appointment — all by phone, computer or the app.

You Pay:
PPO Plan: $10/$30 or $10/$35
HDHP Plan: 10% after your deductible has been met.

STEP 3

Feel Better

Get treated by a provider who can prescribe medication if necessary.

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 the type of visit and your medical plan:

- **PPO Plan:** $10/$30 or $10/$35
- **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.

Same-Day Sick Virtual Visits

When you have a mild illness or health concern, you can schedule a virtual visit to get quality care without leaving home. With a virtual same-day sick visit, a KRMC provider will meet with you via video chat to evaluate your symptoms and create an individualized treatment plan. All you need is a computer, tablet, or smartphone.

Appointments available Monday - Thursday: 7am - 4pm and Friday: 7am - 11am

Step 1: Schedule an appointment through the My KRMC Health Portal. If you don't have an account, you'll need to create one. Please use the name that is on your ID.

Step 2: When it's time for your appointment, log in to your Health Portal. You will enter a virtual "waiting room." When your provider is ready to begin your appointment, they will join you in the portal via video call.

Step 3: Your provider will evaluate your condition and symptoms, ask questions about your health history, and create a care plan for you—including prescription medications as needed.

Some conditions require an in-person visit and cannot be diagnosed or treated with a same-day sick visit.

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

HEALTH SAVINGS ACCOUNT

The High Deductible Health Plan (HDHP) combines comprehensive health care coverage with a savings plan that lets you save for healthcare expenses today, tomorrow, and even for retirement. Together, the Plan rewards you for taking an active role as a health care consumer and making smart decisions about your health care spending. As a result, you could pay less for your annual medical costs.

Are you eligible for a Health Savings Account (HSA)?

In order to establish and contribute to an HSA, you:

- Must be enrolled in a High Deductible Health Plan (HDHP)
- Cannot be enrolled in a traditional Health Care FSA at the same time
- Cannot be enrolled in Medicare, including Part A, or covered by Tricare
- Cannot be a claimed as a dependent on another person's tax return
- Cannot be receiving Social Security benefits

HEALTH SAVINGS ACCOUNT

How a Health Savings Account Works

Eligibility

You must be enrolled in one of the High Deductible Health Plans.

Contributions

To help cover the cost of the deductible, KHI will contribute a fixed amount each pay period to your HSA account. You contribute on a pretax basis and can change how much you contribute from each paycheck up to the annual IRS maximum of $3,850 if you enroll only yourself or $7,750 if you enroll in family coverage. You can make an additional catch-up contribution of $1,000 if you are age 55 and older. It is your responsibility to ensure you do not exceed the IRS contributions each tax year.

Eligible Expenses

Medical, dental, vision and prescription drug expenses incurred by you and your eligible family members.

Using Your Account

Use the debit card linked to your HSA to cover eligible expenses, or pay for expenses out of your own pocket and save your HSA money for future health care expenses.

Your HSA is always yours — no matter what.

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.

If you enroll in Medicare Part A and/or B you can no longer contribute to your HSA. By law, people with Medicare are not allowed to put money into an HSA. This is because you generally cannot have any health coverage other than an HDHP if you are putting money into an HSA. However, you may withdraw money from your HSA after you enroll in Medicare to help pay for medical expenses (deductibles, premiums, copays or coinsurances). If you use the account for qualified medical expenses, it will continue to be tax-free.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) allow you to pay for eligible expenses 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. 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.

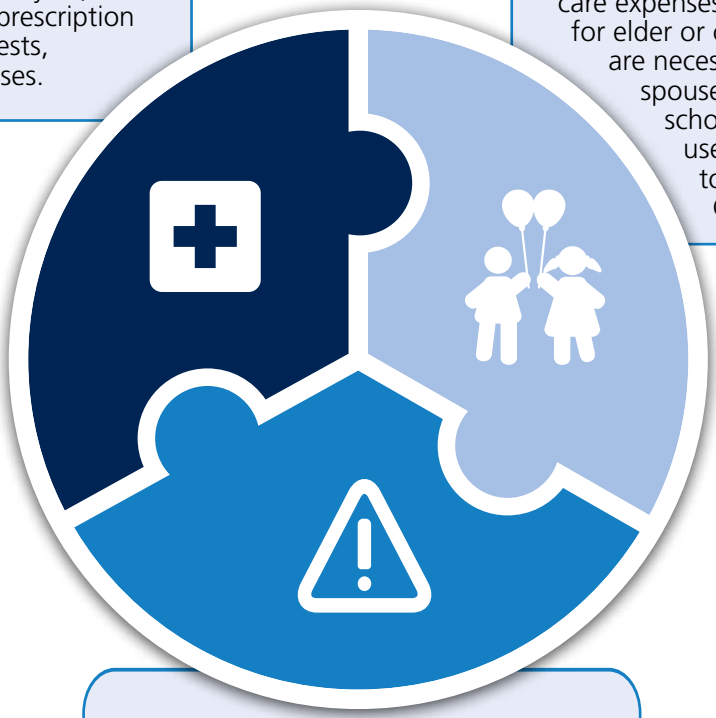
Flexible Spending Accounts are only available to employees who have enrolled in the PPO $1,500 or PPO $500 plan or who have waived medical coverage.

Health Care FSA

Contribute up to $3,050 per year, pretax, to pay for copays, prescription expenses, lab exams and tests, contact lenses and eyeglasses.

Dependent Care FSA

Contribute up to $5,000 per year ($2,500 if married and filing separate tax returns), pretax, to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time. You cannot use your Health Care FSA to pay for Dependent Care expenses.



Use It or Lose It

Our Health Care FSA allows you to carry over $500 in unused funds to the following plan year. Any unused balance over this amount will be forfeited per IRS regulations for pretax contributions.

During Open Enrollment, you must re-enroll in the FSA to be eligible to rollover unused funds. You must elect a minimum of $100 for the plan year.

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.

	PPO Dentist, Premier® Dentist and Out-of-Network Dentist[1]
	You Pay
Covered Services (Combination of in and out-of-net-work)	
Plan Year Maximum Benefit	$2,000
Plan Year Deductible (Individual/Family)	$25 / $75
Lifetime Orthodontia Maximum	Adult and Child $2,000
Preventive Services	
Exams	$0
Routine Cleanings	
Fluoride: For children to age 18	
X-rays	
Space Maintainers	
Basic Services	
Sealants: For children up to age 19	15%[2]
Fillings	
Emergency Treatment	
Endodontics: Root canal treatment	
Periodontics: Treatment of gum disease	
Oral Surgery: Simple extractions	
Oral Surgery: Surgical extractions	
Major Services	
Prosthodontics: Bridges, partial dentures, complete dentures	40%[2]
Bridge and Denture Repair	
Implants	
Restorative: Crowns and onlays	
Orthodontic Services	
Benefit for adults and children age 8 and older	50%
Employee Cost Per Pay Period	
Employee Only	$7.64
Employee + Spouse	$15.66
Employee + Child(ren)	$14.90
Employee + Family	$23.49

[1] Members may incur higher out-of-pocket costs when seeing a Premier or out-of-network dentist. See Covered Dental Services sheet.

[2] Deductible applies to these services. For a complete listing of covered benefits refer to your 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.

	Base Plan		Buy-Up Plan	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	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				
Exams	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	
Employee Cost Per Pay Period				
Employee Only	$0.00		$5.25	
Employee + Spouse	$3.11		$10.77	
Employee + Child(ren)	$3.33		$11.52	
Employee + Family	$5.01		$17.34	

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

** The featured frame allowance is also available if you visit a Visionworks facility.

LIFE INSURANCE

Group Life and AD&D (Employer Paid)

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 – For You		
COVERAGE LEVEL	COVERAGE AMOUNT	EVIDENCE OF INSURABILITY/ PROOF OF GOOD HEALTH
Group Life and AD&D	Maximum benefit of $50,000.	None

Voluntary Life and AD&D (Employee Paid)

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*
Spouse	Increments of $5,000 up to $500,000 – not to exceed 100% of employee coverage.	Required for amounts greater than $25,000*
Child(ren)	$10,000 per child.	None*

* Required if late entrant

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**	**Age**	**Employee**	**Spouse**
15–24	$0.050	$0.070	**65–69**	$1.270	$2.092
25–29	$0.060	$0.079	**70–74**	$2.258	$3.738
30–34	$0.080	$0.093	**75+**	$4.559	$7.225
35–39	$0.090	$0.126			
40–44	$0.130	$0.175			
45–49	$0.208	$0.275	**Child**	$1.76 per $10k benefit	
50–54	$0.326	$0.435	**Employee AD&D**	$0.025 per $1,000	
55–59	$0.494	$0.677	**Spouse AD&D**	$0.034 per $1,000	
60–64	$0.747	$1.194	**Child AD&D**	$0.038 per $10k benefit	

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. All full-time eligible employees begin 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. A full-time employee may accrue 4.62 hours each pay period, 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 healthcare 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 the employee is 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 employees while disabled. These hours cannot be cashed out during employment and have no value at the time of an employee's termination.

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

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 from Unum as part of the approval process.

Long-Term Disability Benefits at a Glance	
Coverage	50% of your pre-disability earnings up to a maximum benefit 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

How EIB and LTD Work Together

PTO pays 100% of your pay until EIB begins. → After 7 days of sickness or injury, approved EIB pays a portion of your income. → After 90 days, LTD begins if approved.

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.

ACCIDENT INSURANCE

Accident Insurance

Accident insurance is a voluntary benefit that pays out 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.

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 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.

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

CRITICAL ILLNESS

Critical Illness Insurance

Critical Illness insurance pays you when are unexpectedly diagnosed with a critical illness such as cancer, stroke, or major organ failure. 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 charge. In addition to the critical illness you are eligible for, your children are also covered under 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.

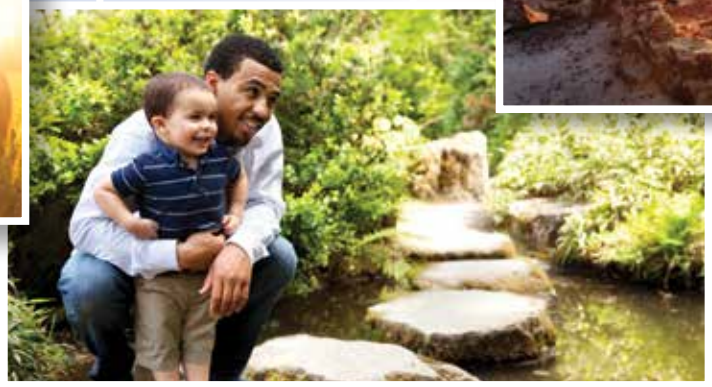
Each covered member is eligible for one of the following benefits every 12 months.

- 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:

- Child care costs
- Medical expenses
- Travel expenses for you and your family
- Lost wages from missed time at work
- Living expenses



HOSPITAL INSURANCE

Hospital Indemnity Insurance

Hospital Indemnity covers one hospital admission per calendar year. 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.

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, child care expenses while you are in the hospital, or cost-of-living expenses as 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. **Note: The plan covers one hospital and one ICU admission per year.**

Hospital		
Hospital Admission	Payable for a maximum of one day per year	$500
ICU Admission	Payable for a maximum of one day per year	$1,000
Hospital Daily Stay	Payable for a maximum of 365 days per year	$100
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

IDENTITY THEFT PROTECTION

Norton LifeLock

Get the all-in-one protection for your identity and devices with the Benefit Essential Plan from Norton LifeLock.

LifeLock Identity Theft Protection 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

LIFELOCK IDENTITY THEFT PROTECTION

- Identity Lock
- Credit, Bank & Utility Account Freezes
- LifeLock Identity Alert System
  - Identity Verification Monitoring
  - Telecom & Cable Applications for New Service
  - Payday - Online Lending Alerts
  - Credit Alerts & Social Security Alerts
- LifeLock Identity mobile app for Android & iOS (Downloading the app does not provide protection until enrollment has been completed.)
- Dark Web Monitoring
  - 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
  - Stolen Funds Reimbursement
  - Personal Expense Compensation
  - 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

LifeLock Rates Per Pay Period

Benefit Essential Plan	Employee Cost Per Pay Period
Employee Only (18+ years old)	$0.00
Employee + Family	$3.25

Benefit Premier Plan*	Employee Cost Per Pay Period
Employee Only (18+ years old)	$3.25
Employee + Family	$8.25

* Upgrade to Premier to include Home Title Monitoring, Credit Score Tracking, 5 devices, and more.

403(b) 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.

Increase Your Retirement Savings With a 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. 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 3 years of employment
  - Up to 4% between 4 and 5 years 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.
- Decide how to invest your 403(b) or allow the plan to choose for you.
- Age 50 or older? Make an additional "catch-up" contribution of up to $6,500 to save even more.

457(b) Plan

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.com** 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

You automatically have access to the Employee Assistance Program (EAP). This program 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
- Child care issues – including identifying schools, day care, tutors and more

UNUM EAP Program

Contact Unum toll-free at:
800-854-1446 (Multi-lingual)
or visit www.unum.com/lifebalance
3 free sessions per issue per year

Uprise Health EAP Program

Contact Uprise Health toll-free at: **800-395-1616**
or visit https://members.uprisehealth.com/
Access Code: KRMC
5 free sessions per issue per year

YOUR WELL-BEING PROGRAM: CULTURE OF HEALTH

We realize the demands of life and work can make it hard to live a healthy lifestyle. The everyday choices we make help us live healthier, happier, and more fulfilling lives, both at work and home. Our vision is that all employees have the support needed to live well and be healthy. The program focuses on the five dimensions of Well-Being: Mental, Physical, Financial, Social, and Occupational. Throughout the year, you will find resources, activities, and opportunities to help you on your journey.

If you are covered by one of the four medical plans, you have access to a digital health app (Sharecare) to help you manage your health and wellness. Discover how your behaviors and conditions affect your calendar age with the RealAge test that provides you with the true age of your body in terms of health and vitality. You'll get personalized insights and information that can help you improve your health and live your healthiest life.

For questions regarding the Well-Being Program, or to become a member of the wellness committee, please contact the Benefits Team at **Benefits@azkrmc.com** or by calling 928-757-0600 option 1.

Good Health, Long Life, More Energy & Greater Happiness

For good health, long life, more energy and greater happiness, among many other benefits, the importance of regular exercise and a proper diet can't be understated. These two factors together are the most pivotal when determining a person's overall health, and adopting them both can make a dramatic difference in how you look and feel.

Health Benefits

According to the U.S. Department of Health and Human Services, a healthy diet means eating lots of fruits, vegetables, whole grains, low-fat dairy products and lean meats and minimizing the consumption of cholesterol, sodium, sugar and saturated fat. In conjunction with regular exercise, a healthy diet can reduce your risk of heart disease, osteoporosis, type-2 diabetes, high blood pressure and some cancers.

Weight

If you're overweight, eating healthy and exercising regularly can help you lose weight safely and keep it off. If you don't have a weight problem, physical activity and a healthy diet can help you maintain your current weight and reduce your risk of gaining extra weight in future years. Healthy foods are generally lower in calories and higher in nutrients than other foods, and regular physical activity burns off extra calories and keeps your metabolism healthy.

Energy

According to the National Institute of Diabetes and Digestive and Kidney Diseases, a combination of working out and eating healthy foods can boost your energy level as well as help you feel more alert and aware, both mentally and physically.

Healthy foods give your body the nutrients and vitamins it needs to function at its best, and even though you use calories and energy through physical activity, the process actually increases the total amount of energy you have.

Mood

Exercise stimulates brain chemicals that help produce feelings of happiness, contentment and relaxation, so you'll feel better if you workout on a regular basis.

According to the Mayo Clinic, physical activity also makes you look better, which is a significant factor in boosting self-confidence and instilling a more positive outlook on life.

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.

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.

Plan Year – The plan year is July-June.

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 a network or non-network provider, but network care is covered at a higher benefit level and you will be responsible for a greater portion of the cost when using a non-network provider.

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.

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 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 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, 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 KHI 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. KHI has determined that the prescription drug coverage offered by the BCBSAZ 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 $2,800
HDHP $1,400
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: 7/1/2023
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

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 the Benefits Team at **Benefits@azkrmc.com** or 928-757-0600, Press 1.

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.

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 January 31, 2023. 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)

[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.

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

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – MEDICAID AND CHIP (HAWKI)

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

KANSAS – MEDICAID

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-766-9012

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

MINNESOTA – MEDICAID

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

MISSOURI – MEDICAID

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

MONTANA – MEDICAID

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

NEBRASKA – MEDICAID

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

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

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – MEDICAID

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

NORTH CAROLINA – MEDICAID
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – MEDICAID
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – MEDICAID AND CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – MEDICAID
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – MEDICAID AND CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) 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
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – MEDICAID AND CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– MEDICAID
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – MEDICAID AND CHIP
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp 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)

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KINGMAN REGIONAL MEDICAL CENTER