KINGMAN REGIONAL MEDICAL CENTER

Benefits Guide

2020-2021

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Welcome to Kingman Healthcare Inc. (KHI)

For Open Enrollment employees: These benefits will take effect starting July 1, 2020. Please read through this benefits guide in full. Valuable information is inside.

For New Benefits Eligible Employees: Your Benefits effective date is the first of the month following date of hire.

Please read through this new benefits guide and all information in your packet in full. Pay special attention and please take the time to thoroughly read all documentation relative to your premiums and coverages. It is your responsibility to know your benefits. The HR team is here to help you make the right decisions about your benefit plans and help you choose the plans that best fit the needs for you and your family.

What are your next steps?

- If you are a brand new KRMC employee, please enroll in your benefits via the Kronos self-service site. There you will complete enrollment into, or waiver of, the Medical, Dental, Vision, Flexible Spending Account (FSA) plans and/or Health Savings Account (HSA). Please remember the FSA or HSA amount(s) you choose will be divided among the remaining paychecks that are left in the plan year (July 1, 2020 - June 30, 2021). **Also note:** FSA Dependent Care is for Child Care NOT Dependent Medical Expenses. Finally, you will also be able to attest to your tobacco usage status and complete the beneficiary information required for the KRMC provided Life Insurance plan.
- If you are an employee who is changing statuses and are now eligible for KRMC Benefits, or you are a rehired, previous KRMC employee, please complete and return to Human Resources your benefits enrollment form, your life insurance beneficiary form, and your non tobacco attestation form(s) for you (and your spouse, if applicable).
- You must bring in your original marriage certificate if you are married and plan to enroll your spouse and/or original birth certificates if you have eligible children and plan to enroll them. (We will make copies as necessary.)
- If you are choosing to waive benefits, you must complete an enrollment form (online or paper) reflecting your decision to waive benefits. Please remember that if you choose to waive your Medical, Dental and Vision benefits, you will not be eligible to elect these benefits again until Open Enrollment, with a July 1 effective date, unless you have a qualifying event. Whether you choose to enroll in or waive benefits, you will automatically be enrolled in the KRMC provided Life Insurance Plan, since it is paid in full by the hospital.
- If you miss your payroll deduction(s) the month in which you are eligible for benefits, you will need to have your premiums caught up. You will receive a separate notification letter of how that will happen.
- DO NOT DELAY returning your enrollment form. You only have 31 days from your benefits start date to enroll.

Any questions, call 928-757-0600, Press 1 or email HumanResourcesBenefits@azkrmc.com.

Benefit Basics

For more information about your benefits, please contact Human Resources at 928-757-0600, Press 1 or HumanResourcesBenefits@azkrmc.com. Benefits fax number is 928-681-8549.

ELIGIBILITY

You are benefits eligible when you meet the eligibility requirements set forth by KHI. Medical, Dental, Vision, FSA or HSA benefits are effective on the first day of the month following your date of hire. Open Enrollment for these benefits occurs annually in May/June, with an effective date of July 1, 2020. Life, STD, LTD and other voluntary benefits are also available for new enrollments and change during open enrollment. (We moved this from December to align with the open enrollment date of our core benefits.)

- Your legal spouse
- Your children up to age 26.

Your benefits will take effect on July 1, 2020 and will remain in effect until June 30, 2021. Remember that you may only change coverage if you experience a qualifying life event, as described here.

QUALIFYING LIFE EVENTS

Generally, you may only make or change your existing benefit elections during the open enrollment window. However, you may change your benefit elections during the year if you experience an event such as:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse, or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of employee, spouse or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- New entitlement to Medicare or Medicaid

You must notify Human Resources within 31 days of a qualifying life event. Depending on the type of event, you may need to provide proof of the event, such as a Marriage Certificate. Human Resources will let you know what documentation you should provide. If you do not contact Human Resources within 31 days of the qualified event, you will have to wait until the next open enrollment window to make changes (unless you experience another qualifying life event).

Benefit Costs

KHI pays for some of your benefits and you share the cost for others, as shown in the graph below.

Benefit	Who Pays	Tax Treatment
Medical Coverage	KHI & You	Pretax
Dental Coverage	KHI & You	Pretax
Vision Coverage	KHI & You	Pretax
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	KHI	N/A
Disability Coverage	KHI	Pretax
Flexible Spending Accounts	You	Pretax
Business Travel Accident Insurance	KHI	Pretax
Employee Assistance Plan	KHI	Pretax
403(b) Retirement Savings Plan	KHI & You	Pretax

Live Well Work Well

We provide online tools and information to help you use your benefits wisely, save money, and make smart choices about the food you eat and staying active. The more you take care of yourself, the healthier we are as a group, which can reduce costs for us all.

Your Health Care Coverage

Your health care coverage includes medical, dental and vision plans. Detailed information about each plan is in this section. If you have questions, please contact Human Resources.

YOUR MEDICAL PLAN

KHI offers two medical plans. At time of service, you choose the tier that meets your needs (and those of your family). Each tier includes comprehensive health care benefits, including preventive care services and coverage for prescription drugs.

- BCBS of Arizona PPO Plan
- BCBS of Arizona HDHP Plan w/HSA

IN-NETWORK/OUT-OF-NETWORK COVERAGE

Each medical plan features in-network and out-of-network coverage; individual and family deductibles; copays; coinsurance; and out-of-pocket maximums. Some offer a lower monthly cost, a higher deductible, and lower coinsurance amounts, while others cost more each month but offer a lower deductible and higher levels of coinsurance.

You may use in-network or out-of-network providers. You will always pay less if you see a doctor or receive services within the provider network because the plan pays more for “in-network services.”

DEDUCTIBLE

You must meet your plan year deductible before the medical plan begins to cover a portion of your costs; however, your HSA and FSA may pay for some of those expenses on your behalf. Once the deductible is met, the medical plan begins to pay for a percentage of covered expenses (this is called coinsurance).

Note that with the HSA, prescriptions are subject to the deductible and out-of-pocket maximum.

OUT-OF-POCKET MAXIMUMS

Out-of-pocket maximums apply to all of the plans. This is the maximum amount you will pay for health care costs in a calendar year. Once you have reached the out-of-pocket maximum, the plan will fully cover eligible medical expenses for the rest of the benefits plan year (except for any copayments). If you see an out-of-network provider, you may be responsible for out-of-pocket costs that are considered above the “reasonable and customary” fees.

HEALTH SAVINGS ACCOUNT

If you are enrolled for family coverage in the plans using a Health Savings Account (HSA), you must meet your individual deductible before coinsurance would apply. The family’s medical costs may be combined to meet the out-of-pocket maximum.

You decide which medical plan will work best for you and your family based on the monthly cost of coverage, the annual deductible, the out-of-pocket maximum, and the funding account you will use.

Medical Coverage – PPO Plan

KHI offers a triple option plan. At time of service, you choose the tier that meets your needs (and those of your family). Each tier includes comprehensive health care benefits, including preventive care services and coverage for prescription drugs.

Plan Provision	TIER 1 KHI Provider	TIER 2 BCBS Provider	TIER 3 Out-of-Network Provider
Annual Deductible (Individual/Family)	$500/$1,500	$1,500/$4,500	$4,500/$9,000
Out-of-Pocket Maximum (Includes Deductible)	$2,250/$4,500	$5,000/$15,000	Unlimited
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Preventive Care	100%	100%	Not covered
Primary Physician Office Visit	$30 copay	$45 copay	50% after deductible
Specialist Office Visit	$30 copay	$45 copay	50% after deductible
X-Ray and Lab	10% after deductible	30% after deductible	50% after deductible
Inpatient Hospital Services	10% after deductible	30% after deductible	50% after deductible
Outpatient Hospital Services	10% after deductible	30% after deductible	50% after deductible
Urgent Care	$50 copay	$125 copay	Not covered
KHI Telehealth Care Anywhere	$5 copay	$20 copay	Not Covered
Telehealth – General	$10 copay	n/a	n/a
Telehealth – Behavioral Health	$30 copay	n/a	n/a
Emergency Room Care	$150 copay	$250 copay	$250 copay
Retail Prescription Drugs (30-day supply) • Generic • Brand Preferred • Brand Non-preferred • Specialty	 $10 $25 $45 $75	 $15 $45 $60 $100	 n/a n/a n/a n/a
Mail Order Prescription Drugs (90-day supply) • Generic • Brand Preferred • Brand Non-preferred • Specialty	 $20 $50 $90 n/a	 $30 $90 $120 n/a	 n/a n/a n/a n/a

Please feel free to call BCBS with any questions at 855-577-6309.

Copays/Formularies are subject to change yearly.
*Your deductible is a plan year deductible – July 1, 2020 through June 30, 2021.
Important notes: This is a synopsis of coverage only; the benefits summary contains exclusions and limitations that are not shown here. Please refer to the benefits summary for the full scope of coverage.

Medical Coverage – HDHP w/HSA

KHI offers a triple option plan. At time of service, you choose the tier that meets your needs (and those of your family). Each tier includes comprehensive health care benefits, including preventive care services and coverage for prescription drugs.

Plan Provision	TIER 1 KHI Provider	TIER 2 BCBS Provider	TIER 3 Out-of-Network Provider
Annual Deductible (Individual/Family)	$2,800/$5,600	$3,500/$7,000	$5,400/$10,800
Out-of-Pocket Maximum (Includes Deductible)	$6,000/$12,000	$6,750/$13,500	Unlimited
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Preventive Care	100%	100%	Not covered
Coinsurance	10%	30%	50%

The HDHP's covered services are subject to deductible and coinsurance. Specific service copays are not applicable in the HDHP. Your coinsurance amount, listed above, is dependent upon where you seek services. The following list of services is an example of services that are subject to deductible and coinsurance.

- Primary Physician Visit
- Specialist Office Visit
- Telehealth – General & Behavioral Health
- Diagnostic Test & Imaging CT/PET Scans, MRIs and x-rays)
- Inpatient Hospital Services
- Urgent Care
- Emergency Room Care
- Prescriptions

Please feel free to call BCBS with any questions at 855-577-6309.

Copays/Formularies are subject to change yearly.
*Your deductible is a plan year deductible – July 1, 2020 through June 30, 2021.
Important notes: This is a synopsis of coverage only; the benefits summary contains exclusions and limitations that are not shown here. Please refer to the benefits summary for the full scope of coverage.

Health Savings Account (HSA)

New with our HDHP Medical Plan

A Health Savings Account (HSA) is one of the more attractive components of your KHI - HDHP Medical Plan. An HSA allows you, the employee, to set aside pre-taxed dollars each payday to pay for medical expenses such as office visits, prescriptions, deductibles and coinsurance. HSAs are savings accounts that never expire. Because these accounts stay active forever, the funds can be available to you well into retirement, when medical expenses are expected to be higher.

KHI will be adding seed money to your HSA. For open enrollment purposes, the entire amount of the seed funds will be in your account July 1, 2020. For employees entering the plan after open enrollment, your seed money will be prorated based on the amount of time you are in the plan for the plan's fiscal year – July 1, 2020 through June 30, 2021.

You are allowed to contribute to your HSA account (up to the IRS established limit) based on your age and your coverage level. For 2020 those amounts are as follows:

Type of Coverage	Employee Age at 2020	IRS Max	Catch Up Contribution	KHI Seed	Max Allowed Combined Employee Contribution
Family	55 +	$7,100	$1,000	$1,000	$7,100.00
Family	Less Than 55	$7,100	N/A	$1,000	$6,100.00
Single	55 +	$3,550	$1,000	$500	$4,050.00
Single	Less Than 55	$3,550	N/A	$500	$3,050.00

Once you reach age 65 you are allowed to spend your HSA on anything, not just qualified medical expenses. This is one reason why HSAs are a great retirement vehicle. As medical purchases are never taxed, the HSA basically converts into a 401(k) or IRA (invest pre-tax, pay taxes later) at the time you turn 65. Conveniently, this is right around retirement time, so your HSA has functioned like an IRA…with a corresponding medical option. As you will see, some distributions after age 65 will still incur a tax, but all distributions will avoid the 20% penalty.

NOTE: you may not contribute to an HSA while enrolled in Medicare. Signing up for Social Security automatically enrolls you in Medicare Part A. There are tax penalties if you do "inadvertently" contribute to an HSA while enrolled in Medicare.

Medical Resources

KHI's Wellness Program

Good health starts with awareness and "knowing your numbers" – Blood Pressure, Total Cholesterol, Blood Glucose and BMI. KHI offers all full-time benefits eligible employees and their covered spouses, if applicable, a chance to earn Wellness Credits by participating in the KHI Healthy Choices incentive program which runs every year from March – May.

To get started on your journey to good health, you will need to complete the following:

1. **Get Your Numbers** – An onsite Biometric Screening event is held every year in March. Starting in January, watch your email for your invitation and all the information you need to participate.
2. **Complete the My BluePrint Health Risk Assessment** – This step is optional. Log onto www.azblue.com and register. You may register as soon as you get your BCBS Medical Cards. Don't wait for the assessment to do so as there is a lot of great information available on the BCBS website.

Once you complete your biometric screening and achieve three out of the four measures in range*, you will be eligible to earn a $60 a month premium incentive to reduce your medical premium deduction! Your spouse, completing those same steps, will be eligible to earn a $30 a month premium reduction.

- Healthy Blood Pressure results (below 135/85)**
- Total Cholesterol Ratio (less than 5)
- Blood Glucose (fasting below 100)**
- BMI (below 30)**
- 5% improvement in any of the above numbers year over year allows you to get credit for that measure even though you are not at the "ideal" range yet.

Non Tobacco User Credit

As a new hire, you will attest to your tobacco status (and that of your spouse) when you enroll in your benefits using Kronos Employee Self-service. If you are a status change or re-hired employee, you will need to complete the form that was enclosed in your benefits packet (for both you and your spouse, if applicable) and return it to HR. In order to receive the Non Tobacco User Credit, you will need to either complete the survey on line, if applicable, or via the non-tobacco attestation form. If you do not answer this survey, you will be ineligible for the non-tobacco user discount, regardless of your tobacco status. You will be defaulted to the tobacco user premium. You must update your tobacco user status at each subsequent annual medical plan open enrollment period in order to qualify for the non-tobacco discount.

For any other questions regarding the KHI Wellness Program, please contact Human Resources.

*If it is unreasonably difficult, due to a medical condition, or medically inadvisable for you to attempt or achieve one or more stated wellness program biometric norms, completing the Physician Attestation Form or a health coaching program may be considered as alternate methods to obtain the wellness incentive. You may request these reasonable alternatives after receiving your biometric screening and failing to meet three of the four measures.

**Measures are subject to change.

Your Dental Plan

It's important to have regular dental exams and cleanings so problems are detected before they become painful—and expensive. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease, and is an important part of maintaining your medical health.

Delta Dental of Arizona has the largest dentist network in the state. With more than 87% of Arizona's practicing dentists enrolled, it's very likely your dentist is in the Delta Dental network. Delta Dental is also the largest National network, offering members more than 148,000 dentists to choose from.

Provision	Delta Dental Plan
Annual deductible Individual/Family	$25/$75
Annual maximum per individual	$1,000
Diagnostic and Preventive, to include cleanings, fluoride treatments, sealants and x-rays	100%, no deductible
Basic Services to include fillings, periodontics, scaling and root planning, oral surgery	85% after deductible
Major Services to include crowns, bridges, full and partial dentures	60% after deductible
Orthodontia (adult and children ages 8 and older)	50%; no deductible $1,000 lifetime maximum

Your Vision Plan

Your vision plan is provided through VSP® Vision Care. It provides coverage for routine eye exams and pays for all or a portion of the cost of glasses or contact lenses. You can see in-network or out-of-network providers; however, you always save money if you see in-network providers. No cards necessary. Make an appointment with an in-network provider and they do the rest.

Benefit	Base Plan (Glasses or contacts every 2 years)		Buy-Up Plan (Glasses or contacts every year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Exam	$10 copay	Up to $50	$10 Copay	Up to $50
Frames	Coverage up to $130-$150 (additional discounts for more frames than allowed)	Up to $70	Coverage up to $160-$180 (additional discounts for more frames than allowed)	Up to $70
Lenses • Single Vision Lenses • Bifocal Lenses • Trifocal Lenses • Progressive Lenses	 $15 copay $15 copay $15 copay $15 copay	 Up to $50 Up to $75 Up to $100 Up to $75	 $15 copay $15 copay $15 copay $15 copay	 Up to $50 Up to $75 Up to $100 Up to $75
Lens Enhancements • Polycarbonate Lenses • Scratch Resistant Coating • Standard Progressive Lenses • Premium Progressive lenses • Custom Progressive Lenses	 $0 copay $0 copay $0 copay $80-$90 copay $120-$160 copay	Contact VSP	 $0 copay $0 copay $0 copay $20 copay $20 copay	Contact VSP
Diabetic Eyecare Plus Program	$20 copay	Not Covered	$20 copay	Not Covered

Flexible Spending Accounts

A Flexible Spending Account (FSA) is a program that helps you pay for health care and dependent care costs using tax free dollars. Each pay period, you decide how much money you would like to contribute to one or both accounts. Your contribution is deducted from your paycheck on a pretax basis and is put into the Health Care FSA, the Dependent Care FSA, or both. When you incur expenses, you can access the funds in your account to pay for eligible health care or dependent care expenses.

This chart shows the eligible expenses for each FSA; how much you can contribute to each FSA each year, and how you benefit by using an FSA.

IMPORTANT INFORMATION ABOUT FSAs

Your FSA elections are effective from July 1 through June 30. Claims for reimbursement must be submitted by September 30 of the following year. Please plan your contributions carefully. Our Healthcare FSA has a rollover provision, which means you may rollover up to $500 per year into the next year's FSA as long as you reenroll in the Healthcare FSA for the following year. This plan is a "use it or lose it" plan so any unused contribution, over the $500 rollover amount, will be forfeited. As such, please carefully consider the amount you wish to contribute to your Healthcare FSA. You must actively enroll each year.

Eligible Expenses	Annual Contribution Limits	Benefit
Health Care FSA Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses and doctor-prescribed over the counter medications)	Maximum contribution is $2,750 per year	Saves on eligible expenses not covered by insurance; reduces your taxable income
Dependent Care FSA Dependent care expenses (such as daycare, after school programs or eldercare programs) so you and your spouse can work or attend school full-time	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns)	Reduces your taxable income

EXAMPLE

Here's a look at how much you can save when you use an FSA to pay for your health care and dependent care expenses.

Account Type	With FSA	Without FSA
Your taxable income	$50,000	$50,000
Pretax contribution to Health Care and Dependent Care FSA	$2,000	$0
Federal and Social Security taxes*	$15,696	$16,350
After-tax dollars spent on eligible expenses	$0	$2,000
Spendable income after expenses and taxes	$32,304	$31,650
Tax savings with the Medical and Dependent Care FSA	**$654**	**N/A**

*This is an example only; not your actual experience. It assumes a 25% federal income tax rate marginal rate and a 7.7% FICA marginal rate. State and local taxes vary, and are not included in this example. However, you will save on any state and local taxes as well.

Your Life and Accidental Death & Dismemberment Insurance Plans

LIFE INSURANCE

Life insurance is an important part of your financial security, especially if you support a family.

KHI provides basic life insurance to all eligible employees at no cost with a maximum benefit of $30,000. Coverage is automatic. You do not need to enroll. Life insurance is not effective until 90 continuous days of employment. Remember to verify your beneficiaries in KRONOS.

AD&D INSURANCE

Accidental Death & Dismemberment (AD&D) insurance is designed to provide a benefit in the event of accidental death or dismemberment.

The company provides AD&D Insurance to all eligible employees at no cost with a maximum benefit of $30,000. Coverage is automatic. You do not need to enroll.

DISABILITY INSURANCE COVERAGE

Disability insurance provides income replacement should you become disabled and unable to work due to a non-work-related illness or injury. KHI provides eligible employees with disability income benefits at no cost as shown below. Coverage is automatic. You do not need to enroll.

Coverage	Benefit
Short-Term Disability/Salary Continuation	• 70% of your base pay • Benefit begins after 7 consecutive days of disability/illness for a maximum of 90 days
Long-Term Disability	• Covers 50% of your base annual earnings, to a $17,500 maximum • Benefit begins after 90 days of disability

Additional Benefits

EMPLOYEE ASSISTANCE PROGRAM

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

ACI's Employee Assistance Program (EAP) provides professional and confidential services to help employees and family members address a variety of personal, family, life, and work-related issues.

EAP and Work-Life Benefits:

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

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

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

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

Reliance Standard Life Insurance Company is licensed in all states (except New York), the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam. In New York, insurance products and services are provided through First Reliance Standard Life Insurance Company, Home Office: New York, NY. Product availability and features may vary by state.

Additional Questions?

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

YOUR EMPLOYEE ASSISTANCE PROGRAM

If you find yourself in need of some professional support to deal with personal, work, financial or family issues, your Employee Assistance Program (EAP) can help. You and your immediate family (spouse or domestic partner, dependent children, parents and parents-in-law) can use the EAP for help with:

- Marriage and family problems
- Job-related issues
- Stress, anxiety and depression
- Parent and child relationships
- Legal and financial counseling
- Identity theft counseling
- Financial planning
- Various other related issues

If you need help or guidance, call a Reliance Standard-ACI counselor at 855-775-4357 or visit http://rsli.acieap.com.

Additional Benefits (continued)

Summary of Paid Time Off (PTO) ** benefit for employees

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

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

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

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

Employee Discount and Other Benefits Summary

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

Cafeteria Services: All employees are eligible to receive a 20% discount in the cafeteria. You must present your employee identification (ID) badge to receive this discount. If you choose to charge your meals with your ID badge, the charges will be automatically deducted from your paycheck.

Gift Boutique: All employees are eligible to receive a 10% discount in the boutique for most items (exceptions apply). A 20% discount is available the first full weekend of the month on those same items. You must present your employee identification (ID) badge to receive this discount. Remember to shop KHI first!

Pharmacy: Employees and their dependents are eligible to receive a discount for Prescriptions filled at the KHI Community Pharmacy with the KHI Medical Plans. Employees are also eligible for discounts on over-the-counter purchases. To receive your discount, you must show your ID badge when you pick up your prescription and/or make your OTC purchase.

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

Additional Benefits (continued)

Summary of Paid Sick Leave

Upon hire, KHI provides Paid Sick Leave benefits to all employees (including full-time, half-time, part-time, temporary, on-call, per diem and seasonal employees) in accordance with Arizona state law. Employees will accrue one hour of paid sick leave for every 30 hours worked. Employees may use up to a maximum of 40 hours of paid sick leave each fiscal year. Accrued but unused sick time is not eligible for transfer or cash out under any other KHI Policy.

Employees may use sick leave for any of the following reasons:

- An employee's mental or physical illness, injury or health condition; an employee's need for medical diagnosis, care or treatment of a mental or physical illness, injury or health condition; an employee's need for preventive medical care.
- Care of a family member with a mental or physical illness, injury or health condition; care of a family member who needs medical diagnosis, care, or treatment of a mental or physical illness, injury or health condition; care of a family member who needs preventive medical care.
- Closure of the employee's place of business by order of a public health official or the need to care for a child whose school or place of care has been closed by order of a public health official.
- Care for oneself or family member when it has been determined by health authorities or a health care provider that the employee's or family member's presence in the community may jeopardize the health of others because of their exposure to a communicable disease.
- Absence due to domestic violence, sexual violence, abuse or stalking, provided the leave is to allow the employee to obtain for the employee or the employee's family member:
  - Medical attention needed to recover from injury or disability caused by domestic violence, sexual violence, abuse or stalking;
  - Services from a domestic or sexual violence program or victim services organization;
  - Psychological or other counseling;
  - Relocation or taking steps to secure an existing home due to the domestic violence, sexual violence, abuse or stalking; or
  - Legal services related to the domestic violence, sexual violence, abuse or stalking

Family member means the following for purposes of this policy:

- Biological, adopted or foster child, stepchild or legal ward, a child of a domestic partner, a child to whom the employee stands in loco parentis (an adult responsible for a child in the place of a parent), or an individual to whom the employee stood in loco parentis when the individual was a minor;
- Biological, foster, stepparent or adoptive parent or legal guardian of an employee or an employee's spouse or domestic partner or a person who stood in loco parentis when the employee or employee's spouse or domestic partner was a minor child;
- Spouse or a registered domestic partner;
- Grandparent, grandchild or sibling (whether biological, foster, adoptive or step) of the employee or the employee's spouse or domestic partner; or
- Any other individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

Please log onto the KHI Intranet - MCN to review the entire Paid Sick Leave Policy.

403(b) Retirement Savings Plan

KHI offers all employees a 403(b) pre-tax retirement account. Transamerica is the retirement plan provider. All employees are eligible for a company match the first quarter after their first full year of eligible employment. Matches are made quarterly on your behalf to your Transamerica account. The generous KHI match schedule is:

- After 1 year of employment — Up to 3%
- After 3 years of employment — Up to 4%
- After 6 years of employment — Up to 6%

You are immediately vested with KHI's 403(b) plan once you start contributing. That means any monies in your account, whether they are your contributions or KHI match funds, are yours to keep upon retirement or termination of your account.

If you are interested in speaking with someone about investment options, please contact our investment representatives, Financial Management Network (FMN), at 949-455-0300. You may also contact Transamerica directly at 800-755-5801.

KHI encourages employees to contribute to a retirement fund, if possible. However, please keep in mind that these funds are not "liquid" and should not be viewed as available before retirement. While our plan does have a provision allowing you to take a loan against your retirement fund, we strongly advise against it. Please only commit to contribute monies you do not expect to need before retirement.

To access the KHI 403(b) plan:
Please sign in at azkrmc.trsretire.com to access your account. The first time you sign in, click **"New user? Get started now"** below the sign-in box to create your customer ID and password.

***You will not be able to locate yourself on this website until AFTER your first paycheck with KHI.*

Don't forget to designate a beneficiary. In the event of your death, it is important to make sure your account is distributed according to your wishes. Home > Beneficiaries or by calling Transamerica.

Check out the Resource Center. Need help figuring it all out? Check out all of the calculators available on Transamerica's website at Resource Center > Calculators.

Benefit Cost

Medical – PPO Plan Coverage through BlueCross BlueShield of Arizona

Bi-Weekly Rates	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical/RX Rate	$99.00	$239.00	$183.00	$294.00
Employee Wellness Credit	- $30.00	-$30.00	- $30.00	- $30.00
Spouse Wellness Credit		- $15.00		$15.00
Employee Non-Tobacco Credit	- $20.00	- $20.00	- $20.00	- $20.00
Spouse Non-Tobacco Credit		- $10.00		- $10.00
Total Deduction with all Credits	**$49.00**	**$164.00**	**$133.00**	**$219.00**

Medical – HDHP Coverage through BlueCross BlueShield of Arizona

Bi-Weekly Rates	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical/RX Rate	$73.00	$153.00	$114.00	$179.00
Employee Wellness Credit	- $30.00	- $30.00	- $30.00	- $30.00
Spouse Wellness Credit		- $15.00		$15.00
Employee Non-Tobacco Credit	- $20.00	- $20.00	- $20.00	- $20.00
Spouse Non-Tobacco Credit		- $10.00		- $10.00
Total Deduction with all Credits	**$23.00**	**$78.00**	**$64.00**	**$104.00**

Dental – Coverage through Delta Dental of Arizona

Bi-Weekly Rates	Plan
Employee Only	$7.75
Employee + 1	$14.50
Employee + Family	$22.00

Vision – Coverage through VSP

Bi-Weekly Rates	Base Plan	Buy-Up Plan
Employee Only	FREE	$5.25
Employee + Family	$4.00	$14.00

Glossary of Medical Plan Terms

Brand Name Drugs—Drugs that have trade names and are protected by patents. Brand name drugs are generally the most costly choice.

Coinsurance—The percentage of a covered charge paid by the plan.

Copayment (Copay)—A flat dollar amount you pay for medical or prescription drug services regardless of the actual amount charged by your doctor or health care provider.

Deductible—The annual amount you and your family must pay each year before the plan pays benefits.

Flexible Spending Account (FSA)—An FSA allows 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—Generic drugs are less expensive versions of brand name drugs that have the same intended use, dosage, effects, risks, safety and strength. The strength and purity of generic medications are strictly regulated by the Federal Food and Drug Administration.

High Deductible Health Plan (HDHP)—A medical plan that may be used in conjunction with a health reimbursement account (HRA) or a health savings account (HSA).

Health Savings Account (HSA)—A fund you can use to help pay for eligible medical costs not covered by your medical plan. Both employers and employees may contribute to this fund; employees do so through pre-tax payroll deductions. Equity partners can have monthly contributions charged against their monthly draw account.

In-Network—Use of a health care provider that participates in the plan's network. When you use providers in the network, you lower your out-of-pocket expenses because the plan pays a higher percentage of covered expenses.

Out-of-Network—Use of a health care provider that does not participate in a plan's network.

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.

Inpatient—Services provided to an individual during an overnight hospital stay.

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

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, except for prescriptions under all medical plans except the HSA Plan.

Primary Care Physician (PCP)—physician (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.

Specialist—A physician who has specialized training in a particular branch of medicine (e.g., a surgeon, gastroenterologist or neurologist).

Contact Information

Plan	Provider	Phone Numbers	Website
Medical	BlueCross BlueShield of Arizona	855-577-6309	www.bcbsaz.com
Pharmacy	Express Scripts (ESI)	877-846-4692	www.express-scripts.com
Pharmacy	KHI Community Pharmacy	928-681-8778	
Dental	Delta Dental	800-352-6132	www.deltadentalaz.com
Vision	VSP	800-877-7195	www.vsp.com
Flexible Spending Accounts (FSA)	Health Equity	866-346-5800	www.healthequity.com
Health Savings Account (HSA)	Health Equity	866-346-5800	www.healthequity.com
Life & AD&D Insurance	Reliance Standard	800-351-7500	
Short-Term Disability Insurance	KRMC	925-263-3227	Jackie.Walker@azkrmc.com
Long-Term Disability Insurance	Reliance Standard	800-351-7500	
Business Travel Accident Insurance	Hartford	800-243-6108	www.thehartford.com
Employee Assistance Program (EAP)	Reliance Standard-ACI	855-775-4357	rsli@acieap.com http://rsli.acieap.com
403(b) Retirement Savings Plan	Transamerica	800-755-5801	azkrmc.trsretire.com
Paid Time Off (PTO)	Human Resources	925-263-3227	Jackie.Walker@azkrmc.com
Voluntary Benefits	UNUM	800-635-5597	www.unum.com

MANDATED HEALTH PLAN INFORMATION REQUIRED FOR FEDERAL COMPLIANCE

Qualifying Events
If you experience a qualified life-status change or if you move out of your plan area, you may add or discontinue coverage that is consistent with the status change, by contacting Human Resources and submitting the proper forms within 30 days of the event.

Qualifying Events include:

- Marriage, divorce, or legal separation
- Birth of a child
- Death of a dependent
- Placement of a child with you for adoption or foster care
- Change in your or your spouse's employment status
- Receiving qualified Medical Child Support Order (QMCSO)

Women's Health & Cancer Rights Act
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.

HIPAA Notification 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 Human Resources, who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights.

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.

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.

Mental Health & Parity Act
The 2010 Wellstone Act added to the requirements of the 1996 Mental Health Parity Act (MHPA). The new act has extended parity requirements to substance use disorder benefits in addition to mental health benefits. It prohibits applying financial requirements (e.g., copayments and deductibles) or treatment limitations (e.g., annual limits on outpatient visits or hospital days) to mental health or substance use disorders unless those requirements and limitations are no more restrictive than those that apply to most medic al and surgical benefits. The act also maintained the MHPA's ban on lower annual or lifetime dollar limits for mental health benefits.

Newborns' and Mothers' 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).

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

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

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. An employer administering a wellness program might include on the relevant forms a warning such as the one set out below.

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.

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 and related companies About Your Prescription Drug Coverage and Medicare

THIS NOTICE APPLIES TO EMPLOYEES AND COVERED DEPENDENTS WHO ARE ELIGIBLE FOR MEDICARE PART D

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 BCBS 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 through 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 KHI coverage will not be affected.

You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

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 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.

needed to participate in the wellness program, or as expressly permitted by law.

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

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

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

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

Date: July 1, 2020

Address: KHI 3269 Stockton Hill Rd, Kingman, AZ 86409

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% 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.

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 KHI's Human Resources Department.

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 July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility:	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE - Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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

LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, 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

1. **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.

Notes

Kingman Regional Medical Center
2020-21 Benefits Guide

ABOUT THIS GUIDE

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