KAIROS
HEALTH ARIZONA, INC.

2024–2025 BENEFITS GUIDE

CHANDLER UNIFIED SCHOOL DISTRICT NO. 80

BEFORE WE BEGIN

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PLAN YEAR

The Kairos plan runs from July 1 to June 30 of each year. That means every July 1, deductibles and out-of-pocket maximums will reset.

WHAT'S NEW?

There are some exciting enhancements this year, called out in the appropriate section in the guide. Just look for anything labeled "new"!

ABOUT THIS GUIDE

This guide provides a summary of benefit options to help you make the right decisions for you and your family.

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

ENROLLMENT CHECKLIST

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

DON'T MISS OUT!

Open enrollment is **April 15–30, 2024.**

Don't miss this opportunity! It's the one time each year you can make changes to your benefit elections (unless you have a qualifying event; see p. 4 for more information).

WHO SHOULD YOU CALL?

Contact our plan providers directly if you have questions or would like more detailed information about our plans. Then, if you need additional assistance regarding your benefits, contact Chandler's Benefits Department.

PLAN PROVIDER	FOR QUESTIONS ABOUT...	PHONE	WEBSITE
UMR	Medical eligibility and benefits; claims and appeals; precertification; ID cards	844.212.6811	UMR.com
MaxorPlus	Prescription benefits	800.687.0707	MaxorPlus.com
Teladoc	Virtual physician visits	800.835.2362	Teladoc.com
ComPsych	Employee assistance program; counseling and work-life services	833.955.3386	GuidanceResources.com
HealthEquity	Health savings account; flexible spending account	866.346.5800	HealthEquity.com
Delta Dental	Delta Dental plan	602.938.3131 800.352.6132	DeltaDentalAZ.com
Total Dental Administrators	TDA DHMO dental plan	888.422.1995	TDAdental.com
VSP	Vision benefits	800.877.7195	VSP.com
MetLife	Basic and supplemental life and AD&D plans; voluntary short-term disability; worksite benefits	877.638.7868	MetLife.com MyBenefits.MetLife.com
MetLife Hyatt Legal	Prepaid legal coverage	800.821.6400	LegalPlans.com
Nationwide	Pet insurance	877.738.7874	Petinsurance.com
WEX Health	COBRA administration	866.451.3399	WexINC.com
LIG Solutions	Health insurance coverage solutions (Medicare, COBRA, individual)	844.214.0598	Partner.LIGSolutions.com/kairos-chandler
Chandler USD Benefits Department	All other benefit-related questions	480.812.7651 480.812.7036	CUSD80.com

PLAN RULES

WHO'S ELIGIBLE?

- ✓ Full-time employees working at least 30 hours per week or job share employees
- ✓ Part-time employees working 20–29 hours (voluntary benefits only)
- ✓ Active board members or council members
- ✓ Dependents of enrolled employees, including:
  - — lawfully married spouses
  - — dependent children up to age 26
  - — unmarried children who are mentally or physically handicapped and fully dependent on the enrolled employee for support and maintenance

THE ELECTIONS MADE DURING THIS ENROLLMENT PERIOD ARE EFFECTIVE FROM

July 1, 2024 to June 30, 2025

WHEN CAN I MAKE A CHANGE?

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

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

Below are examples of qualified life events that may make a mid-year change possible:

- ✓ Marriage, divorce, legal separation, or annulment
- ✓ Birth, adoption, placement for adoption, or legal guardianship of a child
- ✓ Death of a dependent
- ✓ Change in your spouse's employment, or involuntary loss of health coverage under another employer's plan
- ✓ Change in your dependent's eligibility status

Losing medical coverage through the Marketplace is not considered a qualifying event and you cannot join the plan mid-year. You can, however, drop your medical coverage to join a Marketplace plan mid-year.

If you have questions about your eligibility or mid-year changes, contact Chandler Benefits Department.

WHAT DOES IT ALL MEAN?

Let's talk through some health insurance terms and make this easy.

DEDUCTIBLE

This is the amount of money you have to pay each plan year (July to June) for covered services before your health insurance benefits kick in.

COINSURANCE

This is a percentage of covered medical costs you pay once you meet your deductible. The plan pays the rest.

OUT-OF-POCKET MAXIMUM (OOP)

This is the most you'll pay for covered services during the plan year. The out-of-pocket maximum puts a cap on health care costs if you ever have a major illness or injury.

EMBEDDED DEDUCTIBLE

Individual family members have their own deductibles AND there's a deductible for the family as a whole. After an individual meets his or her deductible, the plan begins to pay benefits for that person. Once the family deductible is met, the plan pays benefits for all.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) VS. PPO PLAN

An HDHP is a type of medical plan that has a lower monthly premium but a higher annual deductible. It's usually paired with a health savings account (HSA) to help pay medical expenses.

A PPO is a plan that has a higher monthly premium but a lower annual deductible. PPO plans sometimes have copays for services, unlike HDHPs.

IN-NETWORK VS. OUT-OF-NETWORK

In-network providers are contracted to provide services at a discounted rate. Out-of-network providers are not. Staying in-network is usually the best way to save money on your health care.

INPATIENT VS. OUTPATIENT

Inpatient services are those received when you're admitted to a hospital or facility and spend at least one night. Outpatient services can vary, but they're services received in a facility that you're not admitted to.

PRIOR AUTHORIZATION

This is pre-approval that is required for certain services, prescriptions, and medical equipment to be covered by the plan. It's sometimes called "preauthorization" or "precertification."

Want to learn more?
Scan the code to watch this informational video

How does my medical plan work?

MEDICAL BENEFITS

UMR

UMR is the medical claims processor and uses the UnitedHealthcare (UHC) Choice Plus network. This is a PPO network, which is a group of health care providers who discount what they charge you for services. By staying in-network, services will cost you less.

Where does Kairos fit in?

CUSD
The Plan

CUSD funds all of the health care plans and partners with Kairos to administer your benefits.

UnitedHealthcare
Medical Network

Kairos medical plans use the UnitedHealthcare network. If your doctor asks what network you have, you'll say, "United."

UMR
Claims Handling

UMR processes your medical claims. When you see your doctor, he or she submits the claim to UMR. For questions about your medical coverage, call UMR (not United).

MANAGE YOUR BENEFITS

Create your mobile-friendly account at umr.com to take full advantage of your medical benefits. You'll need to have your ID card handy in order to register.

Once you're in, you can:

- ✓ View/print/order ID cards
- ✓ View medical claims
- ✓ Monitor your deductible and out-of-pocket limits
- ✓ Shop for the best and most cost-effective care

FIND A DOCTOR

If you want to find a doctor, there's no need to log in! Instead, follow these simple steps:

- ✓ Go to umr.com
- ✓ Select "Find a Provider"
- ✓ In the Provider Network search bar, type the network name: UnitedHealthcare Choice Plus
- ✓ Click search, then view providers
- ✓ Type in your address or ZIP code

Now you'll be able to search by provider name, locations, services, and more.

PRESCRIPTION BENEFITS

MAXORPLUS

When you enroll in Kairos medical coverage, you automatically receive prescription drug coverage through MaxorPlus. This benefit allows you to fill prescriptions through any participating pharmacy listed in the MaxorPlus pharmacy network.

Sign up for the MaxorPlus member portal to:

Locate the closest and most cost-efficient network pharmacy

View the plan formulary (a list of prescription medications that may be covered under the plan)

Look up your prescription history and plan costs

TIPS FOR SAVING ON PRESCRIPTIONS

Depending on your medication type, dosage, and frequency, the dollars can add up quickly. But you have options for lowering your out-of-pocket costs. Try these simple steps to help you save a buck or two!

TAKE THE GENERIC

Generics have the same strength and active ingredients as the name brand version of your medications. The only difference is, they're significantly cheaper. Talk to your prescriber to see if generics are right for you.

SHOP AROUND

Just like you might hunt for those great Black Friday deals, you can do comparison shopping for medications. Log in to the MaxorPlus member portal and use the copay calculator to find the most cost-effective pharmacy near you. *(Believe it or not, not all pharmacies charge the same amount for the same medication.)*

USE MAIL ORDER

Mail order delivers medications directly to your doorstep. If you're taking a generic, it will cost you less than it does to go to your local pharmacy. For example, if a prescription costs $25 for a three-month supply at retail, it could cost $20 through mail order. That's like getting three months free every year!

SIGN UP FOR MYMAXORLINK

The myMaxorLink discount program does the work for you. Once enrolled, you'll automatically receive information on lower-cost prescriptions, reminders specific to your coverage, and other important health updates. Call 888.596.0723 to enroll or go to mymaxorlink.com/maxorplus.

NURSES ON *YOUR* SIDE

NURSE NAVIGATORS PROGRAM

KAIROSPRO NAVIGATORS

Navigating health care and insurance can be complicated and leave you feeling overwhelmed. That's where we come in. Through the KairosPro Nurse Navigators program, our dedicated in-house nurses help guide you through the health care system, choose the best treatment, and keep your costs to a minimum.

With this program, you have a real person in your corner who not only has a clinical background but understands your insurance coverage and is there to provide support **at no cost to you.**

How can our nurses help you?

- ✓ Finding in-network providers
- ✓ Assisting with appeals and prior authorizations
- ✓ Reviewing and monitoring claims
- ✓ Obtaining medical and prescription orders
- ✓ Monitoring high-cost medications and medical treatment
- ✓ Coordinating medical services, prescriptions, and durable medical equipment supplies
- ✓ Monitoring inpatient admissions
- ✓ Helping with post-discharge needs
- ✓ Overseeing and collaborating with partner case management programs
- ✓ Arranging for redirection of care, if appropriate
- ✓ Attending onsite biometric screening events and engaging in outreach and follow-up
- ✓ Researching and connecting members with community resources

BONUS: PERSONALIZED MENTAL HEALTH SUPPORT

These days, seeking help for mental health concerns isn't much different from talking to a provider about physical ailments—it's all part of looking after yourself and your health. In this process, Kairos knows it's important to find a support system and professional guidance that work for you. The good news is that your Nurse Navigators team is here to help you:

- ○ Find in-network mental health providers
- ○ Coordinate with your employee assistance program (EAP)
- ○ Line up post-discharge resources
- ○ And more!

Want to speak to a Nurse Navigator? Call the number below or send an email to nurse@kairoshealthaz.org.

A GUIDE TO WELLNESS

WELLNESS PROGRAMS

Our wellness programs—available through KairosPro Wellness—include a variety of options to help promote a healthier and happier you. Take advantage of these offerings at no cost (unless you see a cost listed).

KAIROSPRO WELLNESS

Active&Fit fitness program

Starting at $28/month, you'll get access to 18,000+ fitness centers with no long-term contracts. You can also expect online workout videos, life coaching, and options for enrolling your spouse.

Online wellness center

Our online hub provides wellness activities to keep you on track for healthy eating, weight management, physical activity, and more.

Real Appeal

This is an online weight loss program to help employees make positive lifestyle changes and improve overall health. You can expect to receive a free success kit with enrollment.

Discount tool

Through EmployeeNetwork.com, you can register to receive over 300 exclusive discounts. These include tickets to theme parks, concerts, sporting events, and more.

(Use **Company Code: Kairos Health** when registering)

New!

CARE Programs

Maternity care program: This is for pregnant moms or those who are planning to be. It includes a $25 reward for completion!

Ongoing condition care program: For those who need help when managing chronic conditions like diabetes, COPD, asthma, hypertension, and more, this program is for you.

Complex condition care program: Get assistance with complex cases such as transplants, oncology, high-risk maternity, and neonatal care.

CARE mobile app

Experience personalized and integrated health care solutions through your mobile device.

To sign up or learn more about these programs, scan the code or visit svc.kairoshealthaz.org.

PREVENTION IS PRICELESS

We want to help you stay healthy. That's why the Kairos plan covers preventive care services for free, with no age restrictions when you visit an in-network provider.

Examples of preventive benefits include:

- ✓ Prostate screenings
- ✓ Immunizations and flu shots
- ✓ Hearing exams
- ✓ Mammogram screenings
- ✓ Colonoscopy screenings
- ✓ Cancer screenings
- ✓ Generic contraceptives
- ✓ Blood pressure tests

SKIP THE ER—USE TELADOC

TELADOC

Teladoc allows those enrolled in the medical plan to use their phone or computer to conduct a live virtual visit with a board-certified medical professional—any day, anytime, anywhere.

Teladoc benefits include general medicine, mental health, and dermatology for non-emergency matters like those listed below. For a limited time only, all visits are available to enrollees at no additional cost (until new federal regulations tell us otherwise).

GENERAL MEDICINE	MENTAL HEALTH	DERMATOLOGY
• Cold and flu symptoms • Allergies and sinus infections • Pink eye • Sore throat • Flu symptoms • Medically-necessary prescriptions	• Stress and anxiety • Depression • Trauma • Grief • Burnout • Medication management	• Eczema • Psoriasis • Poison Ivy • Rashes • Rosacea

WAIT! DID YOU REGISTER?

You must create an account through Teladoc before you can access your benefits. Register early so you don't have to worry about it when you're not feeling great. Sign up by scanning the QR code or calling the number listed below.

IMMEDIATE CARE AT A LOWER COST

Skip long lines
Did you know that 60% of patients have to wait at least 2 weeks for an in-office visit with their primary care provider?

Avoid high costs
The average cost for different visit types is as follows:

ER: $2,800
Urgent care: $200
Teladoc: $0

Avoid the long lines, wait times, and expenses of the ER. Use your telehealth benefits 24/7 for non-emergency matters.

WORK & LIFE RESOURCES

COMPSYCH EAP

Everyone can use a little help sometimes. That's where your EAP benefit comes in. Through the employee assistance program (EAP) with ComPsych, you can speak with a highly-trained and compassionate guidance consultant who can help you and your family 24/7 with things like:

Free, Short-Term Counseling

- ✓ Stress and anxiety
- ✓ Relationship/marital conflicts
- ✓ Grief, loss, and life adjustments
- ✓ Substance abuse
- ✓ Minor depression management

Your benefit includes 6 one-on-one counseling sessions per family member, per issue, per year at no cost to you.

Work-Life Solutions

Get the everyday help you need with work-life solutions. Call the number at the bottom of the page for assistance with topics including:

- ✓ Finding child, pet, or elder care
- ✓ Housing searches
- ✓ Seeking financial assistance
- ✓ Will preparation
- ✓ Sending a child off to school
- ✓ Planning a major project or event

ONLINE RESOURCES

You have 24/7 access to vital information, tools, and support through the ComPsych website.

WHAT TO EXPECT:

- Product and service discounts
- Educational articles, podcasts, and videos
- On-demand trainings
- "Ask the Expert" personal responses to your questions

HOW TO ACCESS:

1. Go to guidanceresources.com
2. Click Register
3. Enter Web ID: **KAIROSEAP**
4. Complete your registration

LET'S TALK ABOUT THE PLANS!

PPO PLAN
BENEFIT OVERVIEW

	IN-NETWORK[4]	OUT-OF-NETWORK[4]
DEDUCTIBLE[1]	$2,000/employee $4,000/employee +1 or more	$4,000/employee $8,000/employee +1 or more
OUT-OF-POCKET MAXIMUM[2]	$4,000/employee $8,000/employee + 1 or more	$8,000/employee $16,000/employee +1 or more
OFFICE VISITS	$25 copay primary care physician $50 copay specialist	Deductible, then 50%
URGENT CARE	$50 copay	Deductible, then 50%
EMERGENCY ROOM	$500 access fee, then 20%	$500 access fee, then 20%
WELLNESS SERVICES (ADULT/CHILD)	$0	Deductible, then 50%
TELEHEALTH (TELADOC)[3]	$0	Not available
INPATIENT HOSPITAL OUTPATIENT HOSPITAL	Deductible, then 20%	Deductible, then 50%
OUTPATIENT BEHAVIORAL VISIT	Primary care copay or 20%	Deductible, then 50%
New! CENTERS OF EXCELLENCE ELECTIVE SURGERY AND CANCER CARE BENEFIT	No deductible, $0	Not available

PRESCRIPTIONS

You must meet your prescription deductible first: $100 employee/$300 family

RETAIL (30-day supply)	• Generic: $10 • Preferred: $70 • Non-preferred: $150 • Specialty: 50% (maximum of $180)
MAIL ORDER (90-day supply)	• Generic: $25 • Preferred: $175 • Non-preferred: $375

[1]This plan has an embedded individual deductible and an embedded out-of-pocket limit. This means that although a deductible and out-of-pocket limit apply to the family as a whole, no individual will be responsible for more than his/her individual deductible before the plan pays benefits for that person, and no individual will be responsible for more than his/her individual out-of-pocket limit. All benefits are subject to the deductible, unless otherwise noted.

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

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

[4]The in-network and out-of-network deductibles and out-of-pocket maximums are separate. This means that amounts applied toward the in-network deductible and out-of-pocket maximum do not also apply toward the out-of-network deductible and out-of-pocket maximum. Similarly, amounts applied toward the out-of-network deductible and out-of-pocket maximum do not also apply toward the in-network deductible and out-of-pocket maximum.

Please note: Information provided above may be subject to change at any time.

HDHP LOW
BENEFIT OVERVIEW

	IN-NETWORK[4]	OUT-OF-NETWORK[4]
DEDUCTIBLE[1]	$3,000 employee $6,000/employee +1 or more	$6,000 employee $12,000/employee +1 or more
OUT-OF-POCKET MAXIMUM[2]	$4,750 employee $9,500/employee +1 or more	$9,500 employee $19,000/employee +1 or more
OFFICE VISITS	Deductible, then 20%	Deductible, then 50%
URGENT CARE	Deductible, then 20%	Deductible, then 50%
EMERGENCY ROOM	Deductible, then 20%	Deductible, then 20%
WELLNESS SERVICES (ADULT/CHILD)	$0	Deductible, then 50%
TELEHEALTH (TELADOC)[3]	$0	Not available
INPATIENT HOSPITAL OUTPATIENT HOSPITAL OUTPATIENT BEHAVIORAL VISIT	Deductible, then 20%	Deductible, then 50%
New! CENTERS OF EXCELLENCE ELECTIVE SURGERY AND CANCER CARE BENEFIT	Deductible, then $0	Not available

PRESCRIPTIONS

You must meet your annual medical deductible first, except for preventive medications[5]

RETAIL (30-day supply)	• Generic: $10 • Preferred: $70 • Non-preferred: $150 • Specialty: 50% (maximum of $180)
MAIL ORDER (90-day supply)	• Generic: $25 • Preferred: $175 • Non-preferred: $375

[1]This plan has an embedded individual deductible and an embedded out-of-pocket limit. This means that although a deductible and out-of-pocket limit apply to the family as a whole, no individual will be responsible for more than his/her individual deductible before the plan pays benefits for that person, and no individual will be responsible for more than his/her individual out-of-pocket limit. All benefits are subject to the deductible, unless otherwise noted.

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

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

[4]The in-network and out-of-network deductibles and out-of-pocket maximums are separate. This means that amounts applied toward the in-network deductible and out-of-pocket maximum do not also apply toward the out-of-network deductible and out-of-pocket maximum. Similarly, amounts applied toward the out-of-network deductible and out-of-pocket maximum do not also apply toward the in-network deductible and out-of-pocket maximum.

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

Please note: Information provided above may be subject to change at any time.

HDHP HIGH
BENEFIT OVERVIEW

	IN-NETWORK[4]	OUT-OF-NETWORK[4]
DEDUCTIBLE[1]	$5,000 employee $10,000/employee +1 or more	$10,000 employee $20,000/employee +1 or more
OUT-OF-POCKET MAXIMUM[2]	$6,450 employee $12,900/employee +1 or more	50% coinsurance with no maximum
OFFICE VISITS	Deductible, then 20%	Deductible, then 50%
URGENT CARE	Deductible, then 20%	Deductible, then 50%
EMERGENCY ROOM	Deductible, then 20%	Deductible, then 20%
WELLNESS SERVICES (ADULT/CHILD)	$0	Deductible, then 50%
TELEHEALTH (TELADOC)[3]	$0	Not available
INPATIENT HOSPITAL OUTPATIENT HOSPITAL OUTPATIENT BEHAVIORAL VISIT	Deductible, then 20%	Deductible, then 50%
New! CENTERS OF EXCELLENCE ELECTIVE SURGERY AND CANCER CARE BENEFIT	Deductible, then $0	Not available

PRESCRIPTIONS

You must meet your annual medical deductible first, except for preventive medications[5]

RETAIL (30-day supply)	• Generic: $10 • Preferred: $70 • Non-preferred: $150 • Specialty: 50% (maximum of $180)
MAIL ORDER (90-day supply)	• Generic: $25 • Preferred: $175 • Non-preferred: $375

[1]This plan has an embedded individual deductible and an embedded out-of-pocket limit. This means that although a deductible and out-of-pocket limit apply to the family as a whole, no individual will be responsible for more than his/her individual deductible before the plan pays benefits for that person, and no individual will be responsible for more than his/her individual out-of-pocket limit. All benefits are subject to the deductible, unless otherwise noted.

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

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

[4]The in-network and out-of-network deductibles and out-of-pocket maximums are separate. This means that amounts applied toward the in-network deductible and out-of-pocket maximum do not also apply toward the out-of-network deductible and out-of-pocket maximum. Similarly, amounts applied toward the out-of-network deductible and out-of-pocket maximum do not also apply toward the in-network deductible and out-of-pocket maximum.

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

Please note: Information provided above may be subject to change at any time.

HEALTH SAVINGS ACCOUNT (HSA)

If you enroll in a high deductible health plan (HDHP), you are eligible to open a health savings account with HealthEquity. An HSA is a personal savings account that lets you set aside pre-tax money from your paycheck to use on qualified medical expenses. Some examples of qualified expenses include deductibles and copays, doctor's office visits, prescription drugs, vaccines and screenings, and more! For a complete list, visit learn2.healthequity.com/kairos/qme.

Once you receive your debit card from HealthEquity, you'll be able to use your account. New cards are issued only to first-time enrollees (or if an existing card expires). Because it's your personal account, please contact HealthEquity if you need a replacement debit card.

To view CUSD's annual contribution, turn to page 33.

HSA Advantages

Triple Tax Benefit

Contributions are tax deductible; the funds grow with no tax liability; and money used for health expenses is not taxed upon withdrawal.

It's Yours Forever

The money in your HSA rolls over every year and is yours to keep, even if you leave your employer.

Grow and Save

You can invest the funds, and your earnings grow tax-free. After age 65, you can use the HSA like a traditional retirement account.

YOU'RE ELIGIBLE FOR AN HSA IF:

- You're enrolled in a qualified high deductible health plan.
- You're not also covered by a spouse's non-HDHP employer plan.
- You aren't enrolled in Medicare or another non-qualified health care plan.
- You can't be claimed as a dependent on someone else's tax return.

HOW MUCH CAN YOU CONTRIBUTE?

TIER	MAXIMUM AMOUNT
INDIVIDUAL	$4,150
FAMILY	$8,300
AGE 55+	Additional $1,000

Learn how to maximize your HSA

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

FLEXIBLE SPENDING ACCOUNT (FSA)

Set aside pre-tax dollars for eligible health care and dependent care expenses in a flexible spending account (FSA) administered by HealthEquity. These accounts are also referred to as consumer-driven accounts, or CDAs. You elect how much you want to contribute in equal installments throughout the year.

	MEDICAL REIMBURSEMENT FSA*	LIMITED PURPOSE FSA*	DEPENDENT CARE FSA*
WHAT ARE THE ANNUAL CONTRIBUTION LIMITS?	Up to $3,200 (depending on your employer's plan option)	Up to $3,200 (depending on your employer's plan option)	Up to $5,000 (tax filing status and participation in other plans may affect contribution limits)
WHAT CAN AN FSA BE USED FOR?	Eligible medical, dental, and vision expenses that are not already covered or deducted on your income taxes	Eligible dental and vision expenses that are not already covered or deducted on your income taxes	Eligible childcare expenses
HOW ARE REIMBURSEMENTS MADE?	Claim form submitted via employee portal, fax, or mail	Claim form submitted via employee portal, fax, or mail	Claim form submitted via employee portal, fax, or mail

**Please note that not all FSA accounts may be available, depending on what your employer offers. Contact your employer with any questions.*

NOTE: If you're enrolled in an HDHP with an HSA, you may only contribute to a limited purpose FSA which is used for eligible dental and vision expenses.

ANYTHING ELSE I NEED TO KNOW ABOUT FSAs?

Use it or Lose it—Any money set aside in the FSA must be used for eligible expenses during the plan year. Claims for reimbursement can be submitted up to 90 days after the plan year ends on June 30. After that, funds are forfeited.

Plan Carefully—Your election stays in effect for the entire plan year (July 1 through June 30). Once you make your election, you can only change your contribution amount if you experience a qualified status change (see page 4 for information about status changes).

Keep it Compliant—The IRS clearly defines eligible expenses, and only those that comply with the Internal Revenue Code are eligible for reimbursement. In all cases, itemized documentation for transactions should be retained.

How your FSA works

1

VISIT PROVIDER

Visit your medical/dental/vision/Rx provider and give them your insurance information.

2

PROVIDER BILLS

Your provider will send the claim to your insurance or may bill you directly.

3

PAY YOUR PROVIDER

Use your HealthEquity Visa Healthcare Card to pay your provider, or pay online through the HealthEquity member portal.

DELTA DENTAL INSURANCE

Kairos's dental plan through Delta Dental allows you and your eligible dependents to visit any dentist or specialist without a referral. The plan also travels with you anywhere in the country.

Delta Dental issues ID cards to new enrollees. If you ever need a replacement, please contact Kairos or Delta Dental.

While both PPO and Premier dentists are in-network, you will save more money when using a PPO dentist. Out-of-pocket costs increase by going out-of-network.

NEW: Delta Dental now offers coverage for posterior composites and a third cleaning wellness benefit for those with a qualified medical condition (e.g. diabetes, cancer, periodontal disease, heart disease, and more). To initiate your third cleaning, please contact Delta Dental at the number below.

SELECT PLAN OVERVIEW	PPO AND PREMIER DENTIST	OUT-OF-NETWORK DENTIST
ANNUAL DEDUCTIBLE[1]	$50/individual $150/family	$50/individual $150/family
ANNUAL MAXIMUM BENEFIT[1]	$1,500/individual	$1,500/individual
PREVENTIVE SERVICES (TWICE A YEAR)[2] Exams, fluoride, and cleanings X-rays Sealants: For children up to age 18 Space maintainers Periodontal maintenance	No deductible, $0	No deductible, $0
BASIC SERVICES Fillings Emergency palliative treatment Endodontics: Root canal treatment Periodontics: Gum disease treatment Oral surgery: Simple and surgical extractions	Deductible, then 20%	Deductible, then 20%
MAJOR SERVICES[3] Crown repair Prosthodontics: Bridges, implants, dentures Bridge and denture repair	Deductible, then 50%	Deductible, then 50%
CHILD ORTHODONTIA[4] Braces: For children ages 8–19. (Children must be banded prior to age 17) Lifetime maximum	Deductible, then 50% $1,500	Deductible, then 50% $1,500

[1]Your annual maximum benefit is a combination for in-network and out-of-network services.
[2]Preventive services are charged against the annual maximum benefit.
[3]Major services have a five-year waiting period.
[4]Orthodontia has a separate annual maximum.

TDA DENTAL INSURANCE

Total Dental Administrators (TDA) provides comprehensive dental care on a predetermined fee schedule. There are no deductibles, no claim forms, and no annual or lifetime benefit maximums. Services are covered in the state of Arizona only.

NEW: New TDA ID cards will go out to everyone this year. Be sure your address on file is correct, and be on the lookout for your new cards!

DHMO PLAN
BENEFIT OVERVIEW

	IN-NETWORK COPAY
PREVENTIVE/DIAGNOSTIC	
Initial exam	$0
Adult cleaning	$0
Office visits	$0
RESTORATIVE	
Amalgam (one surface)	$13
Amalgam (two surfaces)	$24
Resin (one surface)	$29
Resin (two surfaces)	$40
CROWN & BRIDGE	
Crown porcelain	$495*
Crown buildup	$80
ENDODONTICS	
Root canal therapy (anterior)	$195
Root canal therapy (molar)	$399
ORAL SURGERY	
Simple extraction	$40
Soft tissue impaction	$90
PROSTHETICS	
Complete denture	$615*
Partial denture	$550*
PERIODONTICS	
Osseous surgery/quad	$390

**Copay includes lab fee. Lab fees may vary; check with your provider for more details.*
Refer to plan summary for a complete list of covered services.

HOW TO USE YOUR PLAN

STEP 1: Access the TDA website prior to making an appointment. Select the general dental office for yourself and your dependents.

STEP 2: Select the DHMO dental plan network and enter your search criteria.

STEP 3: Make note of the provider code number listed to the right of the dental office. You'll use this code number to identify your selection when enrolling for benefits or calling customer service.

Contact TDA customer service at the number below if you need to change your provider mid-year.

VSP VISION INSURANCE

Using your VSP Choice benefit is easy. Simply create an account at VSP.com. Once your account is activated, you can review your benefit information and find an eye doctor who's right for you.

NO ID CARD NECESSARY. At your appointment, tell the office staff that you have VSP. They may ask for additional personal information to verify your coverage. From there, you're good to go. You can also print out an ID card for reference through your online VSP account.

CHOICE PLAN OVERVIEW	IN-NETWORK COPAY	FREQUENCY
WELL VISION EXAM	$10	Every 12 months
ESSENTIAL MEDICAL EYE CARE Retinal imaging for members with diabetes Additional exams to treat pink eye to sudden changes in vision	$20/exam	As needed
PRESCRIPTION GLASSES	$25	See Frames & Lenses
FRAMES $200 featured frame brands allowance $180 frame allowance 20% savings on amount over your allowance $100 Walmart/Sam's Club frame allowance	Included in prescription glasses copay	Every 12 months
LENSES Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for children	Included in prescription glasses copay	Every 12 months
LENS ENHANCEMENTS Standard progressive lenses UV protection Premium progressive lenses Custom progressive lenses	$0 $0 $95–$105 $150–$175	Every 12 months
CONTACTS (INSTEAD OF GLASSES) $150 allowance; copay does not apply Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months

MEMBER-EXCLUSIVE DISCOUNTS

Eyeconic: Save up to $220 on prescription glasses, sunglasses, and contacts with VSP's online eyewear store. Browse the store here, eyeconic.com.

Member Extras: Want access to over $3,000 in savings? Visit vsp.com/offers for discounted offers on LASIK, contacts, hearing aids, and more!

BASIC LIFE AND AD&D INSURANCE

Your employer provides eligible employees with basic life and AD&D in the amount of $50,000. This benefit is at no cost to you, and enrollment is automatic. Administrators receive $200,000 of basic life insurance and AD&D.

Once you reach age 65, the original amount reduces by 35% to $32,500, and then reduces again once you hit age 70 by 50%, to $25,000.

You must designate a beneficiary at least 18 years of age for the basic life insurance benefit. To update your beneficiary information, please log in to Employee Online iVisions, select Benefits, then select HR employee beneficiaries.

SUPPLEMENTAL LIFE AND AD&D INSURANCE

If eligible, you have the opportunity to purchase additional life insurance coverage for yourself, your eligible spouse, and your dependent children. You must elect supplemental life for yourself in order to elect it for your spouse. You are responsible for paying the cost of this benefit as stated in the plan summary. Unlike basic life insurance, your supplemental life insurance amount will not reduce with age. However, the amount you pay in premiums will increase as you age.

	YOU	YOUR SPOUSE	YOUR CHILDREN
AVAILABLE AMOUNTS	$10,000–$500,000 in increments of $10,000 Cannot exceed 5 times your annual salary	$10,000–$250,000 in increments of $10,000 Cannot exceed the combined amount of your basic life and supplemental life benefits	Up to 15 days old: $1,000 15 days to 26 years: $2,000–$10,000 in increments of $2,000
GUARANTEED ISSUE AMOUNT	$150,000	$100,000	$10,000

STATEMENT OF HEALTH PROCESS

You may need to complete a statement of health (SOH) in order to be approved for your supplemental life insurance. Those who need to complete a form are listed below.

If you're enrolling during annual open enrollment and are:
- Electing supplemental life for the first time
- Increasing your supplemental life amount

If you're enrolling as a new hire and are:
- Electing more than the guaranteed issue amount listed above

If you neglect to complete an SOH form, your requested amount will not be approved.

If a statement of health form is needed, please contact your employer or Kairos at the number below. You'll need to ensure you have the appropriate group numbers when submitting the form for approval.

SHORT-TERM DISABILITY INSURANCE

Eligible employees can elect to purchase voluntary short-term disability coverage through MetLife. This benefit replaces a portion of your pre-disability earnings, less any income that was actually paid to you during the same disability from other sources (e.g., Social Security benefits). Disability insurance helps provide income protection for employees with unexpected health events, associated expenses, and possible time away from work due to a non-occupational injury or sickness.

The plan provides weekly benefits in the amount of 40%, 50%, or not to exceed 66 2/3% of your salary up to a $1,500 weekly maximum benefit.

Benefits begin following the plan's 7-day elimination period and are paid for up to 25 weeks of continuous disability. This plan includes maternity as part of the coverage and typically pays six weeks of benefits for a normal pregnancy.

PRE-EXISTING CONDITION LIMITATIONS

The policy does not cover an illness or accidental injury that arose in the three months prior to your plan effective date when enrolling for the first time. In addition, to be eligible for coverage during pregnancy, your pregnancy must occur on or after the benefit effective date (e.g., July 1st, if you are enrolling during open enrollment).

IMPORTANT!

You may sign up for this coverage only during open enrollment, or as a new hire.

You may not drop coverage until the next open enrollment period.

HOSPITAL INDEMNITY (worksite benefit)

Chandler's hospital indemnity plan through MetLife offers a cash benefit when you require hospitalization and are admitted to the hospital. The policy provides one cash benefit per hospital confinement, and cash benefits per day of hospitalization. There are no pregnancy or pre-existing condition exclusions.

COVERED BENEFITS	LIMITS	SITUATION	AMOUNT
ADMISSION BENEFIT	1 time per year	Admission	$500
		Intensive Care Unit (ICU) Supplemental Admission	$500
CONFINEMENT BENEFIT	15 days per year	Confinement	$200
		ICU Supplemental Confinement	$200
INPATIENT REHAB BENEFIT	15 days per year	Inpatient Rehabilitation	$200
HEALTH SCREENING BENEFIT	1 time per year, per person	Health Screening	$50

HEALTH SCREENING BENEFITS AVAILABLE

1. Call MetLife at 877.638.7868.
2. Provide a few details, including: your doctor's contact information; the screening/test and date it was completed; and address of where the screening/test was performed.
3. Receive your free $50.

HOW IT WORKS

On his way to work, Bill's car is hit by a large truck on the highway. Bill is immediately taken to the emergency room at a local hospital. Upon evaluation by the attending doctor, Bill is admitted to the Intensive Care Unit for close observation of trauma to his head and a fractured disk in his neck. After two days in the ICU, he is moved to a standard room and stays there for five more days. Bill is then transferred for in-patient care at a rehabilitation facility. His stay there is seven days. Bill would receive a lump-sum payment totaling $4,200.

COVERED EVENT	BENEFIT AMOUNT
Hospital admission	$500
Supplemental admission ICU	$500
Confinement for 2 days ICU	$800 ($400 per day)
Confinement for 5 days hospital	$1,000 ($200 per day)
Inpatient rehab unit for 7 days	$1,400 ($200 per day)
	$4,200 Total

PREPAID LEGAL COVERAGE

Our legal plans through MetLife provide access to a national network of over 17,000 attorneys to help navigate important life events. Through the program, you can participate in telephone and office consultations with attorneys on a broad range of legal issues.

PREPAID LEGAL ADVANTAGES

- ✓ Telephone advice and office consultation on an unlimited number of legal matters (exclusions may apply)
- ✓ Access to attorneys in person or by phone, email, or mobile app
- ✓ Money-back guarantee
- ✓ No deductibles or copays
- ✓ No claim forms
- ✓ No usage limits

Pick a plan that suits your needs.	LOW PLAN	HIGH PLAN (IN ADDITION TO LOW PLAN BENEFITS)
MONEY MATTERS	• Debt collection defense • Identity theft defense • Negotiations with creditors • Promissory notes • Tax collection defense	• LifeStages identity restoration services • Personal bankruptcy • Tax audit representation
HOME & REAL ESTATE	• Deeds • Eviction defense • Foreclosure • Mortgages • Security deposit assistance • Tenant negotiations	• Boundary & title disputes • Property tax assessments • Refinancing & home equity loan • Sale or purchase of home • Zoning applications
ESTATE PLANNING	• Codicils • Complex wills • Health care proxies • Living wills • Powers of attorney (health care, financial, childcare, immigration) • Simple wills	• Revocable and irrevocable trusts
FAMILY & PERSONAL	• Affidavits • Conservatorship • Demand letters • Garnishment defense • Guardianship • Name change • Personal properties issues • Protection from domestic violence • Review of ANY personal legal document • School hearings	• Adoption • Immigration assistance • Juvenile court defense, including criminal matters • Parental responsibility matters • Prenuptial agreement

Exclusions: *DUI, divorce, felonies, work-related matters, pre-existing legal matters*
Please refer to plan document for a complete list of covered services.

PET INSURANCE

Fetch the best health coverage for your dog or cat through your voluntary benefits package. With two budget-friendly plans plus a $500 wellness benefit option, there's never been a better time to sign up for My Pet Protection®, available only through your workplace benefits program.

GET CASH BACK ON VET BILLS
Choose your reimbursement level of 50% or 70%.

EXCLUSIVE TO YOU
This offer is exclusive to Kairos members.

EASY TO USE
Base plans have a $250 annual deductible and $7,500 in annual benefits.

USE ANY VET, ANYWHERE
No networks, no pre-approvals.

When you're ready to enroll, sign up at petinsurance.com/kairoshealthaz.

BONUS: Plans are available for birds, reptiles, and exotic pets. To learn more or enroll, please call Nationwide at the number below.

IMPORTANT:

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

COMPLETING YOUR OPEN ENROLLMENT

We encourage all employees to take an active role in their initial benefits enrollment process, in monitoring any status changes during the year, and in benefits renewal.

OPEN ENROLLMENT

Your current benefit elections end on June 30, 2024. During the 2024–2025 open enrollment period, you must renew your current elections or make any changes by April 30, 2024. If you miss this deadline, you will NOT have an opportunity to change coverage until next year's open enrollment period, unless you have a qualified life status change. (See p. 4 for examples.)

NEW HIRE

You must elect or decline benefits within 10 calendar days of your date of hire. If you miss this deadline, you will NOT have an opportunity to elect coverage until the following open enrollment period.

LIFE EVENT

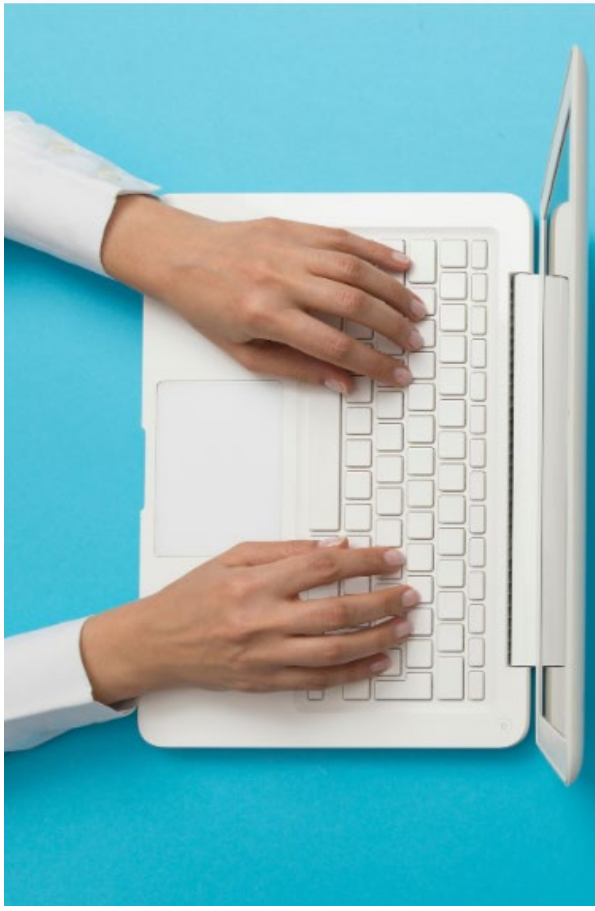
If you experience a qualified life status change, you must submit all necessary paperwork within 31 days of your benefit eligibility date. If you miss this 31-day deadline, you won't have an opportunity to make coverage or benefit changes until next year's open enrollment period.

DURING OPEN ENROLLMENT, ALL REQUIRED INFORMATION MUST BE COMPLETED BY APRIL 30, 2024

Note: If you have coverage elsewhere or through a spouse, your employer plan will become your primary coverage.

APRIL 30

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



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

MID-YEAR CHANGES TO YOUR HEALTH CARE BENEFIT ELECTIONS

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

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

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

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

- change in number or status of dependents (e.g., birth, adoption, death);
- change in employee's/spouse's/dependent's employment status, work schedule, or residence that affects eligibility for benefits;
- have a Qualified Medical Child Support Order (QMCSO);
- have a change in entitlement to or loss of eligibility for Medicare or Medicaid;
- experience certain changes in the cost of coverage, composition of coverage, or curtailment of coverage of the employee's or spouse's plan; and
- have coverage through Medicaid or a State Children's Health Insurance Program (S-CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or S-CHIP coverage ends.
- become eligible for a premium assistance program through Medicaid or S-CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact Chandler Unified School District at 480.812.7036.

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

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

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

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

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

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

Plan limits, deductibles, copayments, and coinsurance apply to these benefits. For more information on WHCRA benefits, contact Kairos at 888.331.0222 or your Benefits Department at 480.812.7036.

PRIVACY NOTICE REMINDER

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

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

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

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

You also do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact Chandler Unified School District at 480.812.7036.

REQUIREMENT TO PROVIDE THE TAXPAYER IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN) OF EACH HEALTH PLAN ENROLLEE

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) for each medical plan participant and include that number on reports that are provided to the IRS each year. If you have a covered dependent who does not yet have a social security number, you can go to this website To request one: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

If you have not yet provided the social security number (or other TIN) for each dependent enrolled in the health plan, please contact your Benefit Department at 480.812.7036.

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.

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

If you or your eligible dependents are currently Medicare-eligible, or will become Medicare-eligible during the next 12 months, be sure you understand whether the prescription drug coverage that you elect through Chandler USD is creditable with (as valuable as) Medicare's prescription drug coverage.

Chandler USD has determined that the prescription drug coverage under the following prescription drug plan options is "creditable": PPO, HDHP Low, and HDHP High.

If you have questions about what this means for you, review the plan's Medicare Part D Notice of Creditable Coverage, which is available from Chandler USD at 480.812.7036.

COBRA COVERAGE REMINDER

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

Qualified beneficiaries are entitled to elect COBRA coverage when qualifying events occur, and, as a result of the qualifying event, coverage for that qualified beneficiary ends. Qualified beneficiaries who elect COBRA continuation coverage must pay for it at their own expense.

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

In addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. You may wish to seek coverage through the Health Care Marketplace. (See https://www.healthcare.gov/.) In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

The maximum period of COBRA coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

In order to have the opportunity to elect COBRA coverage following a divorce/legal separation or a child ceasing to be a dependent child under the plan, you and/or a family member must inform the plan in writing of that event no later than 60 days after the event occurs. The notice should be sent to Chandler Unified School District via first class mail, and should include the employee's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents).

If you have questions about COBRA, contact Kairos at 888.331.0222.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP, and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from the Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial 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).

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 1, 2024. Contact your state for more information on eligibility.

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

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: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

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: 711
Email: masspremassistance@accenture.com

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: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
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://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 1, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
cms.hhs.gov
877.267.2323, menu option 4, ext. 61565

KAIROS HEALTH ARIZONA, INC.

MEDICAL PLAN COVERAGE OPTIONS AND PREMIUMS

Figures below assume enrollment for all 12 months of the plan year.

EMPLOYEE ONLY COVERAGE	TRADITIONAL PPO	HDHP LOW	HDHP HIGH
Annual cost (employee-paid)	$2,240.00	$0	$0
Monthly cost (employee-paid)	$186.67	$0	$0
Annual district deposit into HSA	N/A	$555.00	$1,056.00
Per-pay-period deduction over 22 pays (administrators, teachers, exempt staff, and 12-month support staff)	$101.82	$0	$0
Per-pay-period deduction over 19 pays (support staff who work student calendar, e.g., paras, bus drivers, food service)	$117.89	$0	$0
VOLUNTARY annual maximum employee contribution to HSA	N/A	$3,595.00	$3,094.00

EMPLOYEE + SPOUSE COVERAGE	TRADITIONAL PPO	HDHP LOW	HDHP HIGH
Annual cost (employee-paid)	$13,742.00	$7,552.00	$6,660.00
Monthly cost (employee-paid)	$1,145.17	$629.33	$555.00
Per-pay-period deduction over 22 pays (administrators, teachers, exempt staff, and 12-month support staff)	$624.64	$343.27	$302.73
Per-pay-period deduction over 19 pays (support staff who work student calendar, e.g., paras, bus drivers, food service)	$723.26	$397.47	$350.53
VOLUNTARY annual maximum employee contribution to HSA	N/A	$7,745.00	$7,244.00

EMPLOYEE + CHILD(REN) COVERAGE	TRADITIONAL PPO	HDHP LOW	HDHP HIGH
Annual cost (employee-paid)	$10,611.00	$5,434.00	$4,753.00
Monthly cost (employee-paid)	$884.25	$452.83	$396.08
Per-pay-period deduction over 22 pays (administrators, teachers, exempt staff, and 12-month support staff)	$482.32	$247.00	$216.05
Per-pay-period deduction over 19 pays (support staff who work student calendar, e.g., paras, bus drivers, food service)	$558.47	$286.00	$250.16
VOLUNTARY annual maximum employee contribution to HSA	N/A	$7,745.00	$7,244.00

MEDICAL PLAN COVERAGE OPTIONS AND PREMIUMS

EMPLOYEE + FAMILY COVERAGE	TRADITIONAL PPO	HDHP LOW	HDHP HIGH
Annual cost (employee-paid)	$19,056.00	$11,039.00	$9,896.00
Monthly cost (employee-paid)	$1,588.00	$919.92	$824.67
Per-pay-period deduction over 22 pays (administrators, teachers, exempt staff, and 12-month support staff)	$866.18	$501.77	$449.82
Per-pay-period deduction over 19 pays (support staff who work student calendar, e.g., paras, bus drivers, food service)	$1,002.95	$581.00	$520.84
VOLUNTARY annual maximum employee contribution to HSA	N/A	$7,745.00	$7,244.00

SPOUSAL SHARE FAMILY COVERAGE	TRADITIONAL PPO	HDHP LOW	HDHP HIGH
Annual cost (employee-paid)	$11,808.00	$4,346.00	$3,704.00
Monthly cost (employee-paid)	$984.00	$362.17	$308.67
Per-pay-period deduction over 22 pays (only one spouse pays)	$536.73	$197.55	$168.36
Per-pay-period deduction over 19 pays (support staff who work student calendar, e.g., paras, bus drivers, food service)	$621.47	$228.74	$194.95
VOLUNTARY annual maximum employee contribution to HSA	N/A	$7,745.00	$7,244.00

Employees between 55 and 65 may also make an additional HSA catch-up contribution of $1,000 per year.
Employee contributions are spread equally over either 19 or 22 pays.

DELTA DENTAL

SELECT PLAN

COVERAGE TIER	MONTHLY	ANNUAL	22-PAYS	19-PAYS
EMPLOYEE ONLY	$43.00	$516.00	$23.45	$27.16
EMPLOYEE + SPOUSE	$88.00	$1,056.00	$48.00	$55.58
EMPLOYEE + CHILD(REN)	$73.00	$876.00	$39.82	$46.11
EMPLOYEE + FAMILY	$113.00	$1,356.00	$61.64	$71.37

TOTAL DENTAL ADMINISTRATORS

DHMO PREPAID DENTAL PLAN

COVERAGE TIER	MONTHLY	ANNUAL	22-PAYS	19-PAYS
EMPLOYEE ONLY	$10.40	$124.80	$5.67	$6.57
EMPLOYEE + SPOUSE	$20.80	$249.60	$11.35	$13.14
EMPLOYEE + CHILD(REN)	$22.88	$274.56	$12.48	$14.45
FAMILY	$26.00	$312.00	$14.18	$16.42

VSP VISION

VISION PLAN

COVERAGE TIER	MONTHLY	ANNUAL	22-PAYS	19-PAYS
EMPLOYEE ONLY	$7.19	$86.28	$3.92	$4.54
EMPLOYEE + SPOUSE	$14.39	$172.68	$7.84	$9.09
EMPLOYEE + CHILD(REN)	$15.39	$184.68	$8.39	$9.72
FAMILY	$24.60	$295.20	$13.41	$15.54

METLIFE

HOSPITAL INDEMNITY PLAN

COVERAGE TIER	MONTHLY	ANNUAL	22-PAYS	19-PAYS
EMPLOYEE ONLY	$14.60	$175.20	$7.96	$9.22
EMPLOYEE + SPOUSE	$26.96	$323.52	$14.71	$17.03
EMPLOYEE + CHILD(REN)	$22.76	$273.12	$12.41	$14.37
FAMILY	$35.12	$421.44	$19.16	$22.18

METLIFE — PREPAID LEGAL PLAN

COVERAGE TIER	MONTHLY	ANNUAL	22-PAYS	19-PAYS
LOW PLAN	$7.00	$84.00	$3.82	$4.42
HIGH PLAN	$14.50	$174.00	$7.91	$9.16

METLIFE — VOLUNTARY LIFE

	20–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69	70+
$10,000	$0.67	$0.86	$.0.95	$1.19	$1.51	$2.25	$4.11	$6.25	$11.92	$24.70
$20,000	$1.34	$1.72	$1.90	$2.38	$3.02	$4.50	$8.22	$12.50	$23.84	$49.40
$30,000	$2.01	$2.58	$2.85	$3.57	$4.53	$6.75	$12.33	$18.75	$35.76	$74.10
$40,000	$2.68	$3.44	$3.80	$4.76	$6.04	$9.00	$16.44	$25.00	$47.68	$98.80
$50,000	$3.35	$4.30	$4.75	$5.95	$7.55	$11.25	$20.55	$31.25	$59.60	$123.50
$60,000	$4.02	$5.16	$5.70	$7.14	$9.06	$13.50	$24.66	$37.50	$71.52	$148.20
$70,000	$4.69	$6.02	$6.65	$8.33	$10.57	$15.75	$28.77	$43.75	$83.44	$172.90
$100,000	$6.70	$8.60	$9.50	$11.90	$15.10	$22.50	$41.10	$62.50	$119.20	$247.00
$150,000	$10.05	$12.90	$14.25	$17.85	$22.65	$33.75	$61.65	$93.75	$178.80	$370.50
$200,000	$13.40	$17.20	$19.00	$23.80	$30.20	$45.00	$82.20	$125.00	$238.40	$494.00
$250,000	$16.75	$21.50	$23.75	$29.75	$37.75	$56.25	$102.75	$156.25	$298.00	$617.50
$300,000	$20.10	$25.80	$28.50	$35.70	$45.30	$67.50	$123.30	$187.50	$357.60	$741.00
$350,000	$23.45	$30.10	$33.25	$41.65	$52.85	$78.75	$143.85	$218.75	$417.20	$864.50
$400,000	$26.80	$34.40	$38.00	$47.60	$60.40	$90.00	$164.40	$250.00	$476.80	$988.00
$450,000	$30.15	$38.70	$42.75	$53.55	$67.95	$101.25	$184.95	$281.25	$536.40	$1,111.50
$500,000	$33.50	$43.00	$47.50	$59.50	$75.50	$112.50	$205.50	$312.50	$596.0	$1,235.00

DEPENDENT CHILD COVERAGE MONTHLY CONTRIBUTION				
$2,000	$4,000	$6,000	$8,000	$10,000
$0.304	$0.608	$0.912	$1.216	$1.52

NATIONWIDE — PET INSURANCE

Rates vary by pet breed, age, and location. Refer to website for more information.

Due to rounding, your actual payroll deduction amount may vary slightly.

IMPORTANT: This summary is intended only as a brief description of plan benefits. It attempts to describe plan details in a clear, simple, and concise manner. If there is a conflict between this summary and the wording of plan documents, the plan documents will govern. Kairos retains the right to change, modify, suspend, interpret, or cancel some or all benefits or services at any time.