Catholic Diocese of Lexington
2018 FSA, HSA Enrollment Form

You will be making elections for the **January 1, 2018** through **December 31, 2018** Plan Year. After completing this form, please sign, date, and **return it to your Human Resources Department on or before the end of your enrollment period.**

PARTICIPANT PROFILE – *Please Print Legibly*			
First Name		Home Phone ( ) -	
Middle Initial		Work Phone ( ) -	
Last Name		Date of Birth (mm/dd/yyyy) / /	
Social Security Number		Gender ☐ Female ☐ Male	
Email Address		Marital Status ☐ Married ☐ Single	
Address Line 1		Address Line 2	
City		Date of Hire (mm/dd/yyyy) / /	
State	Zip Code	Division (if applicable)	
Payroll Frequency ☐ Monthly ☐ Semi-Monthly ☐ Other:			
Coverage Level (if applicable) ☐ Individual ☐ Individual/Spouse ☐ Individual/Dependent ☐ Family			

PLAN INFORMATION – *Please Print Legibly*		
Healthcare – Flexible Spending Account (FSA) Out-of-pocket medical, dental, and vision expenses. Contribute up to $2,600 for the plan year (Min $0).	☐ Yes ☐ No	Annual Election $ _____
Dependent Daycare – Flexible Spending Account (DCA)* Child (covered up to 13th birthday) and/or adult daycare expenses. If married filing jointly or single – Contribute up to $5,000 for the plan year. If married filing separately – Contribute up to $2,500 for the plan year (Min $0). **IRS regulations state that a participant may only elect a maximum of $5,000 per calendar year (January thru December). If your plan runs off-calendar or if you are enrolling in a short plan year, keep this in mind when making your election(s).*	☐ Yes ☐ No	Annual Election $ _____
Limited Healthcare – Flexible Spending Account (LMT) ***For HSA Enrollees*** – Used for dental and vision expenses only. Contribute up to $2,600 for the plan year (Min $0).	☐ Yes ☐ No	Annual Election $ _____
Direct Deposit – Used for claim reimbursement directly to your personal bank account. ***NOT to be used for HSA accountholders trying to link a personal bank account.*** Bank Name: _____ Bank 9 Digit Routing Number (Include All Zeros): _____ Bank Account Number (Include All Zeros): _____	Select One: ☐ Begin Direct Deposit ☐ Change Bank Account ☐ Cancel Direct Deposit	Account Type (Select One): ☐ Checking ☐ Savings
Health Savings Account (HSA) – *New enrollees must apply for a bank account.* Qualified healthcare expenses. (Individual: **2018 Max** = $3,450; 55+ = $4,450) (Family: **2018 Max** = $6,900; 55+ = $7,900)	☐ Yes ☐ No	**Your** Per Pay Contribution $ _____
***Renewal Note to HR:** Please update your HSA Contribution Worksheet with the amount listed above (if applicable) & continue sending to your Administrator each pay period.*		

PARTICIPANT AUTHORIZATION	
I hereby authorize my employer to deduct from my salary (if applicable), or other compensation, the required contributions for the amount(s) I have elected above. I agree to comply with the terms and conditions of the plan. I have received and read all acknowledgements & authorizations provided by Chard Snyder for each plan/option elected above on the back of this form.	
Signature	Date / /

HR USE ONLY (FOR MID-YEAR NEW HIRES) – *Must be completed by HR Rep prior to sending to Chard Snyder*		
Employee Effective Date / /	1st Contribution Date / /	Initials

PARTICIPANT ACKNOWLEDGEMENTS & AUTHORIZATIONS (SEE BELOW)

All sections may not apply. Each section is only applicable if you are electing to participate in the plan.

FLEXIBLE SPENDING ACCOUNT – ACKNOWLEDGEMENT & AUTHORIZATION

I understand that:

- I am enrolling in a qualified plan and a description of the plan has been made available to me. I must use the funds I have elected to set aside in my reimbursement account(s) by the end of the Plan Year (as shown above) and submit my claims by the end of the run out period or the funds will be forfeited. If my plan provides a carryover, funds remaining in my FSA reimbursement account will be carried over into the new plan year up to my plan's allowed carryover maximum. Funds remaining above my plan's allowed carryover maximum will be forfeited.
- I cannot change my election once the Plan Year begins; my election(s) must remain in effect for the duration of the Plan Year unless I have a change in family status (marriage, divorce, birth, adoption or death) or in employment status.
- My out-of-pocket expenses must be incurred while I am an eligible participant and during the Plan Year to be considered for reimbursement (the date of service, not the date of invoice, must occur during the Plan Year).
- I cannot itemize and deduct my out-of-pocket expenses again on my IRS Form 1040 for any accounts in which I am enrolled (premiums, health and/or daycare).
- I am required to save all receipts for benefit card purchases in case I should be audited by the IRS.

I hereby authorize my employer to deduct from my salary, or other compensation, the required contributions for the amounts I have elected above. I agree to comply with the terms and conditions of the plan.

HEALTH SAVINGS ACCOUNT – ACKNOWLEDGEMENT & AUTHORIZATION

I understand that:

- An HSA is an individually owned account and I am solely responsible for any tax implications as a result of failing to follow IRS rules & regulations outlined in IRS code Section 223.
- I am required to save all receipts for benefit card purchases in case I should be audited by the IRS.

I agree to have the amount elected on the form pre-taxed from my paycheck on a per-payroll basis. I have read and understand the HSA guidelines and rules and confirm that I am eligible to participate in this benefit. I hereby understand the information on this form and authorize Chard Snyder to complete my request.

DEBIT CARD – ACKNOWLEDGEMENT & AUTHORIZATION:

I understand that:

- I have received, reviewed and understand the procedures of this debit card.
- Benefit card funds are authorized only for the payment of qualified expenses as outlined in my employer's plan document.
- The benefit card may be used only for eligible expenses at the point-of-service, and I may be required to submit a claim form with receipts and/or bills to Chard Snyder to substantiate the expense.
- I cannot itemize and deduct my out-of-pocket expenses again on my IRS Form 1040 for any accounts in which I am enrolled.
- I am required to save all receipts for benefit card purchases in case I should be audited by the IRS.
- If I use my benefit card for ineligible expenses, I will be required to pay back the amount that was not covered by my plan.
- If I do not repay amounts used for ineligible FSA expenses, my employer and/or Chard Snyder has the right to cancel my benefit card and deduct this amount from my salary.
- These FSA funds have not or will not be reimbursed under any other plan coverage.
- Chard Snyder will not be held responsible for processing duplicate claims that I have submitted in error.
- The benefit card may not be accepted at all merchants that accept MasterCard/Visa.
- I must check with my employer to verify the monthly fee, if any, to add to the benefit card.

I understand and agree to the terms and conditions specified on this form and authorize Chard Snyder to complete my request as indicated.

DIRECT DEPOSIT – ACKNOWLEDGEMENT & AUTHORIZATION

I understand that:

- My financial institution can receive transactions via electronic transfer and the bank information provided can serve this purpose.
- I permit Chard Snyder to initiate electronic credit entries and, if necessary, debit entries to reverse erroneous credits to the above account, and to allow the financial institution indicated above to credit and/or debit the same to such account.
- I will not hold Chard Snyder responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me, my employer or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.
- Chard Snyder reserves the right to collect a $25 processing fee for transaction returns and reserves the right to periodically change this fee. Chard Snyder is not responsible for any fees that may be incurred and charged to me by my financial institution.
- Direct deposit of my reimbursements shall commence within 4 (four) weeks of receipt of this form.
- My direct deposit may be terminated by any of the following: an online or written cancellation request submitted by me (when allowed by my employer), a failed bank transmittal due to incorrect bank information, cancellation of direct deposit by my employer or in the event that processing fees are incurred and are unpaid for a period of 60 days.

I hereby agree to and understand the information on this form and authorize Chard Snyder to complete my request.

Terms, Conditions & Account Owner Signature

Important Information Regarding Patriot Act Requirements

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial organizations to obtain, verify, and record information that identifies each individual who opens an account. What this means for you, when you open an account, you are required to provide your name, residential address, date of birth, and identification number. As part of the ongoing maintenance of your account we may require other information or documentation that allows us to identify you. You understand that your HSA may be closed if additional verification is not possible. Upon such closure, funds deposited in your HSA will be returned to you, less any fees or expenses chargeable against your HSA, or penalties or surrender charges associated with the early withdrawal of any savings instrument or other investment in your HSA. As custodian, Healthcare Bank, a division of Bell Bank shall not be liable for any tax consequences or tax withholdings you may incur as a result of the transfer or distribution of your assets.

Important Information about Electronic Payments

I authorize electronic debit and credit entries, if applicable, to my designated checking or savings account. I also authorize adjustments to these accounts for error corrections. This authorization will remain in effect until the termination of your HSA.

Important Information about your Account

The maximum balance allowed in my Cash Account is based on the designated threshold established by my HSA Administrator or me. Amounts over this balance will be automatically swept to my Investment Account as described in the Custodial Agreement and Disclosure Statement made available to me online within my HSA and at www.chard-snyder.com.

Important Information Regarding Death Beneficiary Information

If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary death beneficiary. If any primary or contingent death beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining death beneficiary(ies) shall be increased on a pro rata basis. If more than one primary death beneficiary is designated and no distribution percentages are indicated, the death beneficiaries will be deemed to own equal share percentages in the HSA. Multiple contingent death beneficiaries with no share percentage indicated will also be deemed to share equally. If no primary death beneficiary(ies) survives me, the contingent death beneficiary(ies) shall acquire the designated share of my HSA.

I understand that if I designate my spouse as primary death beneficiary or contingent death beneficiary of the HSA, the dissolution, termination, annulment or other legal termination of my marriage will automatically revoke such designation.

Important Information Regarding My Account Summary

I understand that account summaries are made available electronically and may be viewed at any time by logging into my account at www.chard-snyder.com. The Healthcare Bank Privacy policy is available online at www.healthcarebank.com. For an additional fee, the HSA Administrator may send paper account summaries to my address by U.S. mail.

Important Information Regarding My HSA Investment Account

I understand that once I have accumulated the designated threshold in cash in my HSA as set forth by my HSA Administrator or me in the Application, the balance of my account above the designated threshold will automatically be invested in an interest-bearing, FDIC-insured account. For purposes of this form, "Application" shall mean the WEX Health Cloud® system available through a link provided by my HSA Administrator which provides me access to my HSA information, Investment Account and is used to process my HSA transactions. I may also choose to change my allocation choices and select from the available list of mutual funds for the investment of HSA assets in excess of the designated threshold. The HSA Investment Account is exclusively available online at www.chard-snyder.com. An email address must be included at enrollment or it will not be available. All investment transactions in the HSA Investment Account will be initiated and conducted electronically or by telephone. All required disclosures of investment information and trade confirmations will be made electronically, and by opening an HSA Investment Account I consent to the electronic delivery/access of all documents of any issuer whose securities are made available to my HSA, including issuers and securities made available after the date my account is opened.

Important Information Regarding Substitute W-9 Certification

Under penalties of perjury, I certify that: (1) the Social Security Number shown on this form is my correct taxpayer identification number and, (2) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and (3) I am a U.S. citizen (including a U.S. resident alien).

Important Information Regarding Fees

Any applicable fees shall be deducted from my account. Fees payable in connection with my HSA are set forth on the fee schedule made available to me online within my account.

Important Information Regarding Custodial and Investment Information

I have read and understand the HSA Custodial Agreement and Disclosure Statement made available to me online at http://www.chard-snyder.com/support-center/forms-and-resources/hsa-advantage-custodial-agreement and agree to be bound by those terms and conditions. I understand the eligibility requirements for this HSA and I state that I am responsible for determining whether I qualify to make deposits to this HSA. I am responsible for:

- Determining that I am eligible to make contributions to an HSA for each year I make a contribution;
- Ensuring that all contributions are within the maximum limitations set forth by the tax laws, taking into account my coverage under a high deductible health plan;
- The tax consequences of any contributions (including rollover contributions) or distributions; and
- Seeking the assistance of a qualified tax or legal professional to address any questions or concerns I may have about eligibility, contribution limitations, or the taxation of contributions or distributions from my HSA.

If I choose to select an investment allocation from the available list of mutual funds, I will be solely responsible for direction of the investment of my HSA. I represent that I will carefully review investment information prior to making investment decisions and that I will seek assistance of a financial professional if I have questions about available investment options or how to select investments for my HSA.

I authorize Healthcare Bank, a division of Bell Bank, and its agents to initiate permitted transfers, including contributions, to my HSA, as directed by me or my HSA Administrator through the electronic account service features or as otherwise permitted under this HSA. Any such direction shall remain in effect until Healthcare Bank and its agents receive notice of a change to such directions via the electronic account service features or as otherwise permitted under this HSA.

I certify that the information provided by me on this form is accurate and that I have reviewed the HSA Custodial Agreement and Disclosure Statement and amendments thereto made available to me online at http://www.chard-snyder.com/support-center/forms-and-resources/hsa-advantage-custodial-agreement, as well as the Healthcare Bank Privacy Policy found within the Custodial Agreement. I assume sole responsibility for all consequences found in the form and Custodial Agreement and Disclosure Statement. I understand that I may revoke the HSA on or before the seventh day after the date of establishment. I have not received any tax or legal advice from Healthcare Bank, and I will seek the advice of my own tax or legal professional to ensure my compliance with related laws. I release and agree to hold the Healthcare Bank harmless against any and all claims or losses arising from my actions.

Employer Name ***(Please Print)***	*Employer Division (if applicable)*
Account Owner Name ***(Please Print)***	*Last 4 Digits of Account Owner's SSN*
Account Owner Signature	*Date*

Michael S. Solberg
Authorized Signature of Healthcare Bank as Custodian

NOTICES TO EMPLOYEES REGARDING HEALTH AND WELFARE PLANS

A. HIPAA Special Enrollment Rights Notice

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 the employer stops contributing toward 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 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 30 days after the marriage, birth, adoption, or placement for adoption.

B. The Women's Health and Cancer Rights Act of 1998 (WHCRA) Enrollment/Annual Notice

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 covered 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.

C. Newborns' Act Disclosure

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 of the 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

D. 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 August 10, 2017. Contact your State for more information on eligibility–

ALABAMA – Medicaid	KENTUCKY – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
ALASKA – Medicaid	**LOUISIANA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
ARKANSAS – Medicaid	**MAINE – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
COLORADO – Medicaid and CHIP	**MASSACHUSETTS – Medicaid and CHIP**
Health First Colorado (Medicaid) Website: https://www.healthfirstcolorado.com/ Phone: 1-800-221-3943 / State Relay 711 CHP+ Website: Colorado.gov/HCPF/Child-Health-Plan-Plus Phone: 1-800-359-1991 / State Relay 711	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
FLORIDA – Medicaid	**MINNESOTA – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	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
GEORGIA – Medicaid	**MISSOURI – Medicaid**
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 1-404-656-4507	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005
INDIANA – Medicaid	**MONTANA – 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: http://www.indianamedicaid.com Phone: 1-800-403-0864	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
IOWA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid	SOUTH DAKOTA - Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 1-603-271-5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY – Medicaid and CHIP	**TEXAS – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: http://medicaid.utah.gov CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA – Medicaid	**VERMONT– Medicaid**
Website: http://dma.ncdhhs.gov/ Phone: 1-919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	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
OKLAHOMA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
OREGON – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://mywvhipp.com Phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
RHODE ISLAND – Medicaid	**WYOMING – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-401-462-5300	Website: http://wyequalitycare.acs-inc.com Phone: 1-307-777-7531
SOUTH CAROLINA – Medicaid	
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

E. Medicare Part D Creditable Coverage Notice

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Roman Catholic Diocese of Lexington 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. The Roman Catholic Diocese of Lexington has determined that the prescription drug coverage offered by the Roman Catholic Diocese of Lexington health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th 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 Roman Catholic Diocese of Lexington coverage will not be affected unless you elect to disenroll from the plan.

If you do decide to join a Medicare drug plan and drop your current Roman Catholic Diocese of Lexington coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period for the Roman Catholic Diocese of Lexington benefit plan.

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 the Roman Catholic Diocese of Lexington 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 November to join.

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Roman Catholic Diocese of Lexington changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

For questions on all of the preceding notices, please contact:

Michael Smith
Director of Human Resource
Roman Catholic Diocese of Lexington
1310 W. Main St
Lexington, KY 40508

msmith@cdlex.org

(859) 253-1993 ext 238

October 9, 2017