



Diocese
of Toledo

2026 Benefits Open Enrollment

Employee Information Guide

For additional resources, please visit
www.toledodiocese.org/employee-benefits

Diocese of Toledo Health Benefits Trust

Diocese of Toledo Management Corporation

Office of Human Resources

May 2026

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May 1, 2026

Dear Valued Employee,

We are pleased to introduce our annual Open Enrollment period for the 2026–2027 plan year. This is your opportunity to review your current benefit elections and make any changes for the upcoming plan year, effective July 1, 2026.

As you may recall, last year brought a significant and unexpected increase in healthcare claims, which required adjustments to ensure the continued stability of our Health Benefits Trust. We are grateful to share that during the current year, healthcare utilization has stabilized and returned to more typical levels. This is encouraging and reflects a more predictable environment for the Trust moving forward.

At the same time, the Trust continues to address the longer-term financial impact of last year's claims and manage ongoing increases in healthcare costs such as medical inflation, utilization of services, and prescription drug expenses.

After careful review and with the guidance of our healthcare consultant, Hylant, and the Health Benefits Trust Advisory Committee and Trustees, we will continue our partnership with Anthem for medical coverage and their partner, CarelonRx, for pharmacy benefits for the 2026–2027 plan year.

What to Expect for 2026–2027

- **Medical Plans:** The Premium, Standard, and Advantage Plans will continue to be offered, with no significant changes to plan design.
- **Premiums:** Overall healthcare premiums will increase by an average of approximately 13%, though the exact impact will vary by plan.
- **Employee Contributions:** There will be no change to the employer/employee contribution structure for single coverage. Employees with single coverage who are on the Premium plan will continue to pay 15% of the premium for that plan, or \$186 per month. Employees with single coverage on the Standard Plan will continue to pay 5% of the premium for that plan, or \$53 per month. The Advantage Plan will remain available to employees as a no-cost option for single coverage. *Note: Please consult with the contact person at your employment location who is responsible for benefits to find out the premium cost for two-party or family coverage since that premium calculation continues to be the option of the school/parish/entity.*
- **Benefit Enhancement:** All enrolled health plan members will have access to **LiveHealth Online**, Anthem's telehealth service, at no cost for certain services – offering convenient access to care when you need it.

Open Enrollment will take place from **May 15 through May 31, 2026**. Once again, if you are satisfied with your current medical plan elections, no action is required. If you wish to make changes, you must do so during the Open Enrollment period and elections made during this time will remain in effect for the full plan year unless you experience a qualifying life event.

I encourage you to thoroughly review the Open Enrollment materials found in the packet and at www.toledodiocese.org/employee-benefits to learn more about your healthcare benefits. Then, please log into your MyEnroll360 account to review your current benefit elections and the cost of coverage for the new plan year, which begins July 1, 2026.

If you have any questions about the materials contained in this packet, please contact your parish/school business manager or Karla Icsman, Human Resources Generalist, at 419-214-4888 or kicsman@toledodiocese.org.

We recognize that any increase in healthcare costs can be challenging. Please know that we continue to administer diocesan benefits with great care, thoughtful analysis, and prayerful consideration. Our goal remains to provide high-quality, sustainable benefits while being responsible stewards of financial resources.

Thank you for your continued dedication to the mission of the Diocese of Toledo and for the important work you do each day in our parishes, schools, and ministries. Be assured of our gratitude and prayers.

Sincerely,

A handwritten signature in cursive script that reads "Meghan Reed".

Meghan Reed
Director of Human Resources



Diocese of Toledo Health Benefits Trust 2026 Open Enrollment Information

**Benefits Open Enrollment runs May 15 – May 31, 2026 for
the new benefit year which begins July 1, 2026**

Visit www.toledodiocese.org/employee-benefits for additional
information and resources.

Important Reminders

- ✓ **All benefit elections/changes can be made online at www.MyEnroll360.com between May 15 and May 31, 2026. See pages 6-7 for information about logging in to MyEnroll360 to make your Open Enrollment elections.**
- ✓ All benefit-eligible employees should log in to MyEnroll360 during the Open Enrollment period to review plan options, costs, and make their elections.
- ✓ If you would like to change from your current plan election (Premium Plan, Standard Plan, or Advantage Plan) to a new plan, effective July 1, 2026, you may do so through MyEnroll360 during the Open Enrollment window.
- ✓ If you are not currently enrolled in the healthcare plan, if you wish to cancel coverage on the healthcare plan, or if you wish to enroll/cancel coverage for your spouse/dependent(s) you may do so through MyEnroll360 during the Open Enrollment window. These changes will be effective July 1, 2026.
- ✓ If you do not log in to MyEnroll360 during the Open Enrollment window, your current healthcare plan election will remain in place for the 2026-2027 plan year and the new employee contributions will be deducted from your payroll beginning in July.
- ✓ If you participated in one or more Flexible Spending Accounts (medical or dependent care) in the current year, and wish to participate in the new 2026-2027 plan year, you **MUST** make a new election for the new plan year.
- ✓ If you enroll in the Advantage Plan, you will receive additional information about your Health Savings Account (HSA) in the mail from Anthem and their HSA custodian, WealthCare Saver. You should also review the Diocese of Toledo, HSA Participant Information guide, to learn more about setting up your Health Savings Account through payroll deduction.

If you have any questions about our annual Open Enrollment, please contact your parish/school business manager or bookkeeper. You may also contact Karla Icsman Human Resources Generalist: 419-214-4888 or kicsman@toledodiocese.org



The Diocese of Toledo Health Benefits Trust partners with Benefit Allocation Systems (BAS) to offer online benefits administration through www.MyEnroll360.com.

The following benefit elections will be made online for this year's Open Enrollment:

- ✓ Healthcare Plan Choice
- ✓ Dental Coverage (if offered)
- ✓ Vision Coverage (if offered)
- ✓ Healthcare Flexible Spending Account
- ✓ Dependent Care Flexible Spending Account

MyEnroll 360

Open Enrollment is your annual opportunity to make benefit changes for the upcoming plan year, which begins on July 1, 2026. Open Enrollment will be conducted **online** at www.MyEnroll360.com, where you can find all the information you need to make your benefit elections. **The 2026 Open Enrollment period begins on Friday, May 15, 2026, and ends on Sunday, May 31, 2026.**

MyEnroll360 will walk you through your benefit options, and contains a helpful Library with all of your benefits information in one place. You can review your plan options, see the cost of coverage, and learn more about our health insurance carrier, Anthem. You will log in to MyEnroll360 and go through each benefit to make your elections. We feel it is important for everyone to go through all your benefits to make sure that your elections reflect the coverages you need for yourself and your family.

During the Open Enrollment window (Friday, May 15 - Sunday, May 31), you can do the following online at www.MyEnroll360.com:

- ✓ Change from your current plan election to the Premium Plan, Standard Plan, or Advantage Plan effective July 1, 2026.
- ✓ Elect coverage if you are not currently enrolled, cancel coverage, or enroll/cancel coverage for your spouse/dependent(s) effective July 1, 2026.
- ✓ Make Healthcare and/or Dependent Care FSA elections for the 2026-2027 plan year, which begins July 1, 2026.

Interested in a Flexible Spending Account (FSA) for the 2026-2027 Plan Year?

Healthcare and Dependent Care Flexible Spending Accounts (FSA) allow you to set aside *pre-tax dollars* from your paycheck to pay for eligible unreimbursed out-of-pocket health and dependent care expenses that you and your family incur. If you are not currently participating in either account, then you may be paying for these expenses with *after-tax dollars*. By using a Flexible Spending Account, you can save money on taxes and benefit from more of the money you earn. You can learn much more about the FSA programs when you log-in to your MyEnroll360 account.

If you participated in one or more Flexible Spending Account (FSA) in the current year, and you wish to participate in the new 2026-2027 plan year, you MUST make a new election for the new plan year.

Important Note: You cannot contribute to a healthcare FSA if you enroll in the Advantage Plan and plan to contribute to a Health Savings Account (HSA).

Making your Online Elections

The enrollment site at www.MyEnroll360.com is available 24 hours a day, 7 days a week during the Open Enrollment period. When you are ready to make your elections, follow these steps:

1. Go to www.MyEnroll360.com and enter your User Name and Password. If you have forgotten your User Name or Password, please see troubleshooting guide on next page.
2. Complete the Multi-Factor Authentication (MFA) process, more information on this can be found under troubleshooting on the next page.
3. Follow the easy enrollment steps using the Enrollment Wizard.
4. Complete your benefit selections.
5. Approve your elections.
6. Print your benefits confirmation statement.

If you need to make changes to your elections, you may do so as long as it is within the Open Enrollment period. The Open Enrollment period will close at 11:59 p.m. on Sunday, May 31, 2026.

If you need more detailed information or assistance

Detailed information about your benefit plans will be available in MyEnroll360 in the online Reference Library link under "Quick Links" or in "Tools" found under the left menu bar. You must log-in with your User ID and Password to access this resource.

If have questions while you are using MyEnroll360, you may contact Benefit Allocation Systems, LLC. (BAS) at Service@BASusa.com or call 1.800.945.5513 from 8:30 a.m. to 5:00 p.m. EST, Monday through Friday.

Note: If you do not have internet access or need help with accessing the technology needed for your online enrollment, please contact your supervisor or your parish/school business manager for assistance.

If you do not know your username, have forgotten your password, or are in need of further assistance, please contact BAS MyEnroll Client Services at 1-800-945-5513.

Thank you in advance for your cooperation through our Open Enrollment process.

Diocese of Toledo Healthcare Plan FAQ

updated May 2026

Benefits and Plan Designs

What is the cost of healthcare coverage?

2026-2027 Cost Sharing for SINGLE coverage

	Single Coverage Employer Contribution	Single Coverage Employee Contribution
Premium Plan	85%	15% (\$186/month)
Standard Plan	95%	5% (\$53/month)
Advantage Plan (HDHP)	100%	No Cost



Please consult with your benefits administrator or business manager at your employment location to find out the premium cost for two- party or family coverage since that premium calculation continues to be the option of the school/parish/entity. You can also view that information when you log in to www.MyEnroll360.com.

What are the differences between the different plan options?

Please visit or <https://toledodiocese.org/employee-benefits> to view the Summary of Benefits and Coverage (SBC) documents for all three of the plans offered. The following chart will give you a general idea of the differences between the three plans.

Summary of In-Network Plan Benefits

	Premium Plan	Standard Plan	Advantage Plan (HDHP with HSA)
Deductible	Single- \$500 Family-\$1,000 <i>Embedded Deductible</i>	Single - \$1,500 Family - \$3,000 <i>Embedded Deductible</i>	Single- \$2,000 Family-\$4,000 <i>Non-Embedded Deductible</i>
Coinsurance (employee pays)	10% after Deductible	30% after Deductible	20% after Deductible
Coinsurance Maximum (does not include deductible and co-payments)	Single- \$1,500 Family-\$3,000	Single - \$2,500 Family- \$5,000	Single- \$2,000 Family-\$4,000
Maximum Out of Pocket (the limit a member will pay for all covered services in a plan year)	Single - \$6,600 Family - \$13,200	Single - \$6,600 Family- \$13,200	Single - \$4,000 Family - \$8,000
Primary Care Physician Office Visit	\$20 copayment	\$30 copayment	20% after deductible
Specialist Office Visit	\$30 copayment	\$40 copayment	20% after deductible
Emergency Room	\$100 copayment	\$150 copayment	20% after deductible
Prescription Drugs	Generic - \$5.00 Brand - 30%	Generic - \$10.00 Brand - 30%	Generic - 20% after deductible Brand - 20% after deductible

How do I choose which plan is best for me?

You will need to take some time to evaluate your personal situation and compare the plan options to decide which plan is best for you. Consider questions such as:

- What are your healthcare needs during a typical year? How often do you (and your family members, if applicable) go to the doctor? Do you have a chronic health condition that you receive ongoing treatment for? Do you anticipate any elective surgeries in the upcoming year? Do you anticipate becoming pregnant and having a baby this year?
- If you have a serious illness or injury, what deductible and out-of-pocket maximum can you afford?
- What is the difference in the monthly premium? If you choose the Standard Plan or the Advantage Plan, are you disciplined enough to set that money aside to use in the event of a serious illness or injury?

A [plan comparison tool](#), designed to help you evaluate your plan options based on your individual situation is available at www.toledodiocese.org/employee-benefits. This tool allows you to estimate your healthcare utilization for the plan year and then calculates your total annual cost under each plan option, including both the premium you pay and your estimated out-of-pocket healthcare expenses.

What is the difference between an Embedded Deductible (Premium and Standard Plans) and a Non-Embedded Deductible (Advantage Plan)?

The annual deductible is the amount you pay before insurance pays.

Embedded Deductible (Premium/Standard Plan) – The individual deductible is part of the family deductible, so no one member can contribute more than the individual amount. Once a member meets the individual deductible, they move to copays/coinsurance, while other family members may still have deductible costs until either their individual deductible or the family deductible is met.

Non-embedded Deductible (Advantage Plan) – This is a true family deductible. Individual deductibles don't apply—everyone's expenses count toward the family deductible. Once it's met, copays/coinsurance apply to all members.

I have decided to enroll in the Advantage Plan, but how do I go about setting up a Health Savings Account (HSA)?

Anthem partners with WealthCare Saver to open a Health Savings Account (HSA) for employees enrolled in the Advantage Plan. You will receive more information, including an HSA debit card, in the mail from Anthem and WealthCare Saver. Once the HSA account is opened, you may set up a direct deposit from your payroll to contribute to your HSA through payroll deduction on a pre-tax basis. Contact your business manager or bookkeeper for more information. Information about the Advantage Plan and HSA is located on the Diocese of Toledo website: <https://toledodiocese.org/employee-benefits>, and the library tab in your MyEnroll360 account

Can I change my mind and switch plans mid-year?

Once the Open Enrollment period closes, you cannot change the plan you are enrolled in until the next annual open enrollment period. If you experience a qualifying life event, you can enroll in or cancel coverage for yourself or your dependents in conjunction with that qualifying event, but you cannot change plans.

How can I learn more about my Anthem coverage?

It is important that you understand what services are covered on your benefit plan and understand how to make the most of your healthcare benefits through Anthem. Details about the Anthem plan benefits can be found in the [2026-27 Diocese of Toledo Employee Benefits Guide](#) and [2026-27 Employee Wellness Guide](#) online at <https://toledodiocese.org/employee-benefits>.

We are very pleased to have the Anthem Health Guide team serving our employees. **You can reach the Anthem Health Guides at 1-833-388-1403.** These specially trained customer service agents can help you with any question about your plan and will go above and beyond to walk you through the health care system.

Anthem offers a variety of tools, available on their website www.anthem.com and on their Sydney Health mobile app (available for both Apple and Android devices). You can also access the [2026-27 Employee Benefits Guide](#) and [2026-27 Employee Wellness Guide](#) about Diocesan benefits on the Human Resources page of the Diocese of Toledo website: <https://toledodiocese.org/employee-benefits> and through your MyEnroll360 account.

How can I find out if my physician or hospital is in Anthem’s provider network? You can search for your providers at <https://www.anthem.com/find-doctor/>. You can also contact Anthem Member Service at 1-833-388-1403 and an Anthem Health Guide will assist you with your search.

Enrollment

Whether you are currently enrolled in the plan or not, it is important to pay attention to these enrollment details.

I am satisfied with the plan I am currently enrolled in and do not wish to make any changes this year. What do I do now?

We are glad you are pleased with your current elections but ask that you still access MyEnroll360 and go through each benefit to review your coverage and confirm your elections with an e-signature.. If you do not log in to MyEnroll360 during the Open Enrollment window, your current healthcare plan election will remain in place for the 2026-2027 plan year and the new employee contributions will be deducted from your payroll beginning in July. If you participated in one or more Flexible Spending Accounts (FSA) in the current year, and you wish to participate in the new 2026-2027 plan year, you **MUST** make a new election for the new plan year.

I have considered my plan options and I would like to change the plan I am enrolled in. What do I do now?

You will need to log in to www.MyEnroll360.com during the Open Enrollment window to change your current election (Premium Plan, Standard Plan, Advantage Plan) to a new plan. The Open Enrollment window will close at 11:59 p.m. on **May 31, 2026**. The plan change will be effective July 1, 2026. You will receive an email with additional instructions about logging in to MyEnroll360. More information can be found on pages 6-7.



Making a change? All Open Enrollment changes are made online at www.MyEnroll360.com

Can I enroll or drop coverage for my spouse or dependent(s) during Open Enrollment?

Yes. Open Enrollment is your opportunity to make these types of changes to your healthcare coverage. You will need to log in to www.MyEnroll360.com during the Open Enrollment window to change your elections for your spouse or dependent(s). The Open Enrollment window will close at 11:59 p.m. on **May 31, 2026**. The plan change will be effective July 1, 2026.

If I decide not to enroll or make changes now, will I be able to do so at a later date?

Employees are automatically defaulted to participate in the Section 125 qualified plan, which allows for payroll deductions to be taken on a pre-tax basis. In order to make a plan change during the year, you must experience a qualifying life event.

If you do not enroll now, you will only be able to enroll under two circumstances:

1. You (and your eligible spouse and dependents) can enroll or cancel your coverage if you have a “qualifying life event.” A qualifying event will allow you or an eligible family member to enroll immediately.
2. You can enroll during the next Open Enrollment period. Open Enrollment occurs annually each spring for coverage effective July 1.

If you are already enrolled in the plan, a qualifying life event **only** allows you to add coverage for your spouse/dependents, or to cancel coverage. A qualifying life event **does not** give you the opportunity to change which benefit plan (Premium Plan, Standard Plan, or Advantage Plan) you are enrolled in.

What is a “qualifying life event”?

Qualifying events are defined by the Internal Revenue Service (IRS) and include situations such as:

- You get married
- You have a child or add one to your family (through adoption, marriage, qualified medical child support order, etc.)
- Your spouse or dependent becomes unemployed
- Your spouse or a child dies
- Your dependent(s) become(s) ineligible for plan benefits
- Your spouse’s employment status changes
- You or your spouse take an unpaid leave of absence
- You or your dependent(s) lose other group health insurance coverage



If any of these events occur, you will need to make your new election in MyEnroll360 within 30 days of the date of the life event. More information on submitting a life event in MyEnroll360 can be found online at

<https://toledodiocese.org/employee-benefits>. Contact the Diocesan Human Resources office or your local benefits administrator for more information.

In the case of a newborn baby, please don't forget to enroll the baby in healthcare coverage within 30 days of the baby's birth! If you add the baby to your Diocese of Toledo Healthcare Plan coverage, and the addition of the baby changes your coverage tier to two-party or family, you will be charged the additional premium beginning with the date of the baby's birth. If you have any questions about newborn coverage, please contact Anthem customer service. Above all, congratulations on your new blessing!

Eligibility

In addition to Diocesan priests and members of certain religious orders, all lay employees of the Diocese may participate in the Diocese of Toledo Healthcare Plan if they:

- work at least twenty-five (25) hours per week for more than five (5) consecutive months per year; and**
- are working for an entity that participates in the healthcare program.**

Employees are eligible if they work the total required number of hours at one or more locations.

Am I eligible for coverage on the Diocese of Toledo Healthcare Plan even if I am eligible for coverage or already covered on another plan?

All employees who meet the eligibility requirements are eligible to enroll in the Diocese of Toledo Healthcare Plan. However, please remember that this coverage is provided to you at a significant cost to your employer. If you are already enrolled in another plan, please carefully consider the cost that your employer will incur if you enroll in this plan as well.

If you and/or your family members are enrolled in another healthcare plan and you are considering enrollment in the Diocese of Toledo Healthcare Plan as well, it is important for you to understand how the two benefit plans will coordinate. The Plan that covers the person as an employee is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. As the Primary Plan, this plan will provide benefits to employees without regard to any other plan they may be enrolled in. If you are enrolled in another plan as a Secondary Plan, it is up to you to determine how that plan may coordinate benefits with this plan.

For more information on coordination of benefits between two plans, please refer to your plan documents.

What are the rules concerning dependent eligibility?

The Diocese of Toledo Healthcare Plan is subject to the federal law related to dependent eligibility that requires the plan to extend dependent coverage for children up to age 26. The dependent can be married

or unmarried, does not have to reside in the same household as the employee, does not have to be a student, and does not have to be financially dependent on the employee.

Eligibility for dependents past age 26 will continue only for eligible dependents who are unmarried and primarily dependent upon the enrolled employee for support due to a physical handicap or intellectual disability which renders them unable to work. Please contact Anthem for complete details.

Please keep in mind that both the Diocese of Toledo and Anthem reserve the right to verify that an enrolled spouse/dependent is in fact eligible for coverage on the plan. You could be financially responsible for any claims paid by the Plan for any spouse/dependent who is later deemed ineligible.

Additional Benefits

Does the Diocese of Toledo Healthcare Plan include dental and vision benefits?


If you are enrolled in diocesan healthcare coverage with Anthem, this coverage does NOT include dental and vision benefits. Parishes/Schools may opt to offer dental and/or vision benefits through Guardian.

If your employer offers these additional benefits:

- **Effective July 1, 2026, vision coverage will transition from the VSP Signature Plan to the VSP Choice Plan**, which is VSP's most widely used plan. While overall coverage remains similar, there will be some minor changes to benefits. Most notably, certain services that were previously available on a rolling 12- or 24-month cycle will now be based on the calendar year. [A summary of the VSP Choice Plan](#) is available at <https://toledodiocese.org/employee-benefits>
- During the annual Open Enrollment period, you can view your current elections and make any necessary changes online at www.MyEnroll360.com

New! What is LiveHealth Online and how does it work?

[LiveHealth Online](#) is a **telehealth** service provided through Anthem that allows you to connect with a doctor or licensed therapist by video using your smartphone, tablet, or computer. You can use [LiveHealth Online](#) for common, non-emergency medical needs—such as colds, flu symptoms, allergies, or minor infections—as well as behavioral health support.



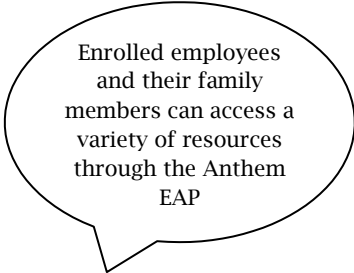
New! Benefit Enhancement effective July 1, 2026.

For the 2026–2027 plan year, **LiveHealth Online will be available at no cost to you** for certain services when you are enrolled in a diocesan medical plan. This offers a convenient way to access care without needing to travel to a doctor's office.

To request a virtual care visit via [LiveHealth Online](#), [log in to your Anthem account](#) and choose **Care**, then select **Virtual Care**. You can also [download the SydneySM Health](#) mobile app. The Sydney app will connect you to a healthcare professional through a video visit.

Does the Diocese of Toledo offer an Employee Assistance Program (EAP)?

Employees who are enrolled in any of the Diocese of Toledo healthcare plan options (Premium, Standard, or Advantage) have access to Anthem's EAP program. Life can be full of challenges, and the Anthem EAP is there to help you and your household members. The Anthem EAP offers a wide range of no-cost support services and resources, including: counseling (up to 6 visits per issue, in person or online), legal consultation, financial consultation, dependent care and daily living resources, online tools, and much more. To connect with the Anthem EAP and access these free and confidential services, call 1-800-865-1044 or visit www.anthemEAP.com and enter "Diocese of Toledo" when prompted for a "Company Code".



Enrolled employees and their family members can access a variety of resources through the Anthem EAP

What is a Flexible Spending Account (FSA) and how can I enroll?

A Flexible Spending Account Plan (FSA) offers an easy and convenient way for you to save money on taxes and make your benefit dollars go further. If you participate in a Health Care and/or Dependent Day Care FSA, your employer puts money aside from your paycheck (before taxes are taken out) and you use that money to pay for eligible health care and/or dependent day care expenses.

Elections to participate in an FSA are an annual election, meaning that you must make your election to participate during each annual Open Enrollment period. Those elections will be made online at www.MyEnroll360.com. To learn more about the FSA, please visit www.toledodiocese.org/employee-benefits.

Advantage Plan – The Diocese of Toledo IRS-qualified High Deductible Health Plan (HDHP) with an HSA

What is a High Deductible Health Plan (HDHP)?

An HDHP is a health insurance plan with lower monthly premiums and higher deductibles than traditional plans. You pay more out of pocket before insurance starts paying for most healthcare expenses. It can be paired with a Health Savings Account (HSA).

What is a Health Savings Account (HSA)?

An HSA is a tax-advantaged savings account you can use to pay for qualified medical expenses. You can contribute pre-tax dollars to it and withdrawals for qualified medical expenses are tax-free. The funds roll over year to year and the employee maintains the account when employment ends.

To be eligible to contribute to an HSA, you must:

- ✓ be enrolled in a qualified HDHP
- ✓ not be enrolled in Medicare
- ✓ not be claimed as a dependent on someone else's tax return
- ✓ not be enrolled in a Flexible Spending Account (FSA)

What types of medical expenses can be paid with funds in an HSA?

Examples of qualified medical expenses which can be paid with your HSA debit card include: costs that count toward your deductible; coinsurance (your share of medical costs); co-payments; emergency room or urgent care visits; prescription drugs; hospital stays; and many dental and vision expenses. Please refer <https://qme.anthem.com/> for a detailed list of qualified expenses.

Can anyone have an HSA?

No, the IRS only allows employees with an IRS-qualified HDHP is permitted to open and contribute to an HSA. **Diocese of Toledo healthcare plan participants must be enrolled in the Advantage Plan to have an HSA.** Employees on the Premium Plan and Standard Plan are not permitted to have an HSA.

Can I contribute to both an HSA and an FSA?

No, you cannot contribute to a healthcare FSA if you are contributing to an HSA.

How do I set up and contribute to my HSA?

Anthem partners with WealthCare Saver to open a Health Savings Account (HSA) for employees enrolled in the Advantage Plan. You will receive more information, including an HSA debit card, in the mail from Anthem and WealthCare Saver. Once the HSA account is opened, you may set up a direct deposit from your payroll to contribute to your HSA through payroll deduction on a pre-tax basis. Contact your business manager or bookkeeper for more information. **Note: the Advantage Plan does NOT have an employer contribution to the HSA. All HSA's are 100% funded by employees.**

How can I learn more about the Advantage Plan (HDHP) and HSA?

The information on the following pages will assist you. If you are interested in participating in the Advantage Plan. You are encouraged to review this information to learn more about how to make the

plan and the HSA work for you. As a reminder, you are only eligible to have an HSA if you are enrolled in the Advantage Plan, the Diocese of Toledo's IRS- qualified high deductible plan.

To learn more about the tax advantages and IRS rules related to HSA's, please visit <https://www.irs.gov/forms-pubs/about-publication-969> and <https://www.irs.gov/forms-pubs/about-publication-502>.

If you enroll in the Advantage Plan, you will receive additional information about your Health Savings Account (HSA) in the mail from Anthem and their HSA custodian, WealthCare Saver. You will also find valuable information regarding setting up payroll deductions to contribute to your HSA inside the [HSA Participant Guide](#) located on the Diocesan website at: www.toledodiocese.org/employee-benefits.

The information included in this document and at www.toledodiocese.org/employee-benefits does not constitute legal, tax, or benefit plan design advice. We strongly encourage you to consult with a tax advisor before establishing a health savings account. Any health savings account will be established between the individual account holder and the HSA custodian, WealthCare Saver. Anthem is responsible for the administration of the health plan, and the custodian is responsible for the administration of the HSA.



2026 Benefits Open Enrollment

May 15, 2026 – May 31, 2026

Helpful Links

[Plan Comparison Tool](#) – use this calculator to add your employee contribution to your anticipated health plan utilization to estimate your total annual costs under all three plan options.

Access additional information from Anthem about your healthcare benefits by visiting www.toledodiocese.org/employee-benefits. for more resources including:

- Healthcare Benefit Plan Options – Premium, Standard, and Advantage (HDHP)
- Summary of Benefits and Coverage (SBC) documents for all plan options
- Year-round benefits information on your healthcare through Anthem Blue Cross/Blue Shield in the [2026-27 Employee Benefits Guide](#)
- Information on programs offered by Anthem partners programs including diabetes prevention, telehealth services and Anthem Employee Assistance Program in the [2026-27 Employee Wellness Guide](#).
- Anthem tools, resources, and more!

Educational Videos:

[What is a Health Savings Account \(HSA\)?](#)

[Pairing a High Deductible Health Plan \(HDHP\) with an HSA](#)

[How to optimize your HSA](#)

[How to stretch your healthcare dollars](#)

When you're ready, visit www.MyEnroll360.com to make your Open Enrollment elections!

A copy of this guide and additional Diocese of Toledo benefit information can be found online at www.toledodiocese.org/employee-benefits

If you have any questions about our annual Open Enrollment, please contact your parish/school business manager or bookkeeper. You may also contact Karla Icsman Human Resources Generalist: 419-214-4888 or kicsman@toledodiocese.org

Sydney Health

Discover a powerful, more personalized health app



SydneySM Health makes healthcare easier. Using this mobile app, you can securely access your personal health and wellness information wherever you are. Use Sydney Health anytime to:



Access your digital ID card

Your digital ID card is always up to date. Show, email, or fax it to your doctor right from the app.



Find support

Receive emotional and mental health guidance, or connect to your Employee Assistance Program (EAP) 24/7.



Manage your benefits

Review coverage and claims, and receive important details about your plan.



Find care

Search your plan's network for a doctor and other healthcare professionals. Connect directly to care through a video visit.



Chat with us

Get answers about your plan benefits through live chat.



Get motivated

Plan and track your health goals, physical activity, and health rewards.

Try Sydney Health today



Scan the QR code with your phone's camera.



Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2024

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/co/networkaccess. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. and Community Care Health Plan of Georgia, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In 17 southeastern counties of New York: Anthem Healthchoice Assurance, Inc., and Anthem Healthchoice HMO, Inc. In these same counties Anthem Blue Cross and Blue Shield HP is the tradename of Anthem HP, LLC. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield, and its affiliate HealthKeepers, Inc. trades as Anthem HealthKeepers providing HMO coverage, and their service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Get the most from your health plan

Your health savings account (HSA) can help cover costs

Using your Anthem plan's health savings account is a smart way to make your healthcare dollars work even harder.

Because you can contribute tax free, your money goes further. Pay for care and other eligible expenses anytime you need it.*

The money you put in your account is always yours to keep, even if you switch health plans, change jobs, or retire. Any unused funds also roll over from year to year, and they never expire.

Use your HSA to pay for healthcare costs, such as:

- Ambulance and emergency services
- Coinsurance (your percentage of the costs)
- Copays
- Deductible payments
- Hospital fees
- Lab tests
- Noncosmetic prescription drugs

For a full list of qualified medical expenses, please visit qme.anthem.com.



Invest your HSA funds to save even more

After your HSA balance reaches \$1,000, you can invest anything over that amount. Your contributions will grow tax-free and can help you pay for future medical expenses.

To view your investment options, log in to the SydneySM Health app or anthem.com and go to Spending Accounts.



How to use your HSA



1 Add money to your HSA anytime or contribute through paycheck deductions.

In 2026, you can add up to \$4,400 for individuals or \$8,750 for families.



2 Look out for your debit card in the mail.

Your HSA debit card works the same as a regular debit card once you activate it

If you have Apple Pay, Google Pay, or Samsung Pay on your smartphone, you can also pay touch-free when you add your HSA debit card to your mobile wallet. Simply follow your phone's instructions to add a new debit card. Then, use your phone to pay for qualified expenses where mobile payments are allowed.



3 Use your mobile wallet or HSA debit card to pay for doctor visits, prescriptions, and other qualified medical expenses.

You can also use the HSA online bill-pay tool to pay medical bills or reimburse yourself with the funds in your account. When a new claim comes in, you can log in to your account and pay the bill or reimburse yourself from your HSA.



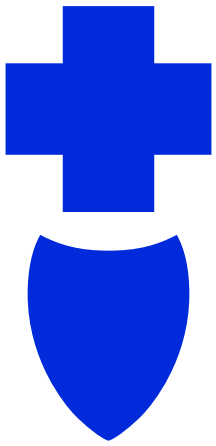
4 Log in to [anthem.com](https://www.anthem.com) or download the SydneySM Health mobile app to:

- See your HSA balance and claims.
- Find a doctor in your plan's network.
- Check costs before you receive care.
- Set your preferences to receive important information electronically.

* For a full list of eligible medical and dental expenses, visit irs.gov/pub502.

Sydney Health is offered through an arrangement with Caredon Digital Platforms, a separate company offering mobile application services on behalf of your health plan.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to [anthem.com/co/networkaccess](https://www.anthem.com/co/networkaccess). In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. and Community Care Health Plan of Georgia, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In 17 southeastern counties of New York: Anthem Healthchoice Assurance, Inc., and Anthem Healthchoice HMO, Inc. In these same counties Anthem Blue Cross and Blue Shield HP is the trade name of Anthem HP, LLC. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield, and its affiliate HealthKeepers, Inc. trades as Anthem HealthKeepers providing HMO coverage, and their service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.



Your health savings account

Frequently asked questions

Health savings account (HSA)

Q: What is an HSA?

A: An HSA is a tax-free savings account that's paired with a high-deductible health plan (HDHP). By law, to open or contribute to an HSA, your medical plan must be a qualified HDHP. The required deductible is set by the Internal Revenue Service (IRS) each year. The contribution limit for 2026 is \$4,400. You can use the money in your HSA to pay for qualified medical expenses (QME). For a full list of QMEs, visit [gme.anthem.com](https://www.gme.anthem.com). You can also save money in your HSA for future healthcare costs. The account grows with interest and you have investment options after your account reaches a minimum balance of \$1,000. The HSA belongs to you and the money in the account is yours to keep, even if you leave your employer.

Q: How is my HSA funded?

A: Your HSA is funded by pretax contributions, up to a certain annual limit. If you choose to contribute money to your HSA after taxes are taken out, you can claim the contributions on your tax return. Others, employer contribution, may contribute to your account as well. You can earn additional dollars for your HSA by taking certain steps to improve your health. The total of all contributions cannot be more than the maximums defined by the IRS. (See the question: How much can I contribute to my HSA? for details.)

The IRS has specific rules on who can open an HSA. See those rules in [IRS Publication 969](#).¹



Health savings account (HSA) *continued from page one*

Q: I'm a veteran with a service-connected disability. Can I contribute to an HSA?

A: Yes. A 2016 amendment to the eligibility rules allows veterans with a high-deductible health plan, no disqualifying coverage, and a service-connected disability to make or receive HSA contributions, regardless of when they received benefits from the Department of Veterans Affairs (VA). This amendment also applies to contributions from the veteran's employer. Veterans with a service-connected disability are not blocked from HSA eligibility because they accessed VA benefits in the past three months.

If a veteran receives VA medical benefits for a non-service-connected disability during the prior three months, they are not eligible to make or receive HSA contributions.

Q: Can I have an HSA if my spouse is on Medicare?

A: Yes, as long as you're not enrolled in Medicare and you meet the IRS eligibility requirements for an HSA. If you contribute to an HSA and cover your spouse on your plan, you can use your HSA funds to pay for qualified medical expenses for you and your spouse on Medicare.

Q: My spouse is enrolled in Medicare. Can they also be enrolled as a dependent on my HSA?

A: Yes, but your spouse cannot open an HSA account in their name. You may use your HSA to pay for **qualified medical expenses for you and your spouse on Medicare**.

Q: Who can use the money in an HSA?

A: The money can be used to pay for qualified medical expenses for you, your spouse, or any IRS-qualified dependent who you claimed on your income taxes, even if they're not covered on your health plan. Talk with a tax advisor to find out if these rules apply to your tax situation. You can also go to [irs.gov](https://www.irs.gov) to find out who qualifies as a dependent.

Q: I am enrolled in an HSA. Can I continue to contribute to my spouse's HSA and use their bank?

A: You and your spouse can continue to make contributions to their HSA, but you can't contribute more than the IRS family contribution maximum between both accounts. For 2026, the family contribution maximum is \$8,750.

Q: My child is under 26, but I no longer claim them on my taxes. Can I still cover them using my HSA?

A: The IRS has specific rules about covering children and children of divorced or separated parents. Please see [IRS Publication 969](#) and talk with a tax advisor. You can cover dependents under age 26 but you can't use your HSA for their expenses unless they meet the following requirements:

- You can claim the child on your tax return.
- Your child is under age 19, or age 24 if a full-time student or totally and permanently disabled.

Dependents who don't qualify to receive funds from your HSA may qualify to open their own HSA and could be permitted to contribute up to the family maximum (for 2026, this is \$8,750). They can contact a financial institution to discuss how to set up a separate HSA.

Health savings account (HSA) *continued from page two*

Q: What's the difference between an HSA and a healthcare flexible spending account (HCFSA)?

A: Both HSAs and HCFSAs can be funded with-pretax dollars and can be used to pay for qualified medical expenses. However, HSA balances roll over from year to year, while HCFSAs are generally forfeited if not spent during a 12-month period. Additionally, if you leave your employer, your HSA dollars are yours to keep but HCFSAs are forfeited.

Q: Can I have an HSA and an FSA?

A: Yes, you can have both an HSA and a compatible FSA, as long as it's defined as a:

- **Limited-Purpose FSA**, which may be limited to dental or vision services.
- **Post-Deductible FSA**, which also allows for dental or vision services, as well as paying for coinsurance under the traditional health component of your plan, after meeting the deductible.
- **Dependent Care FSA**, which allows you to use tax-exempt funds to pay for childcare expenses that you incur while at work. Employees can also use FSAs to cover adult daycare expenses for elderly family members who live in the home.
- **Commuter Benefits**, which pay for work transportation and parking. You have until TEST 01, 2026 to use the funds in this account or the funds will be forfeited.

Making contributions to your HSA

Q: How much can I contribute to my HSA?

A: The annual contribution maximum in 2026 is \$4,400 for individual coverage and \$8,750 for family coverage. The maximums are set by the IRS and may increase every year due to inflation. Check [irs.gov](https://www.irs.gov) for the most current maximum amounts.

Q: Can I ever contribute more than the annual limit?

A: Yes, people age 55 and older who are not enrolled in Medicare can contribute an extra \$1,000 above the regular limits. This is called a "catch-up contribution." These individuals can make catch-up contributions each year until they enroll in Medicare.

Only the account holder can make catch-up contributions. The contribution amounts allowed are subject to proration if you are enrolled in the plan less than 12 months or under other circumstances. Catch-up contributions can be made in the same way your regular contributions are made.

Making contributions to your HSA *continued from page three*

Q: What if my spouse has an HSA, too?

A: The chart below explains different situations:

If your spouse:	And you have:	Then, the IRS:
Has PPO (preferred provider organization) self + children coverage.	HDHP (high-deductible health plan)self-only coverage.	Treats you as having single coverage and only you may set up an HSA. You may contribute up to \$4,400.
Has HDHP self-only coverage with a \$1,650 deductible.	HDHP self + child coverage with a \$3,300 deductible.	Treats you both as having family coverage, and combined you may contribute up to \$8,750 to your HSAs.
Has HDHP self + family coverage with a \$3,300 deductible.	HDHP self + spouse coverage with a \$8,750 deductible.	Treats you both as having family coverage, and combined you may contribute up to \$8,750 to your HSAs.
Is enrolled in Medicare.	HDHP self + family coverage only.	Will only allow you to set up an HSA. You may contribute up to \$8,750.

Q: Does tax filing status (joint vs. separate with my spouse) affect my HSA contribution?

A: Tax filing status does not affect your contribution. Contribution limits are based on whether you have single or family medical plan coverage, not your tax filing status.

Q: Can I use my HSA to pay for eligible expenses for my spouse even if we file our taxes separately?

A: Yes, the IRS requirements simply refer to eligible expenses for the “spouse” — they do not include requirements for filing jointly or separately.

Q: Can I contribute to an HSA if my spouse has an HCFSAs?

A: Usually, a healthcare FSA covers the expenses of the participant and their spouse and dependents. If your spouse has an HCFSAs, it most likely covers your healthcare costs. If so, then you won't be able to make contributions to your HSA.

There are exceptions to this rule. An example if your spouse's HCFSAs is a limited-purpose HCFSAs that only covers dental and vision costs. See [IRS Publication 502](#).²

Q: Can I use my HSA to pay for medical expenses I had before my account was set up?

A: No, you cannot be reimbursed for qualified medical expenses from before the date your HSA was established.

Making contributions to your HSA *continued from page four*

Q: What happens if I have a medical expense early in the year and there isn't enough money in my HSA to cover my out-of-pocket costs?

A: An HSA works like a bank account. You can only spend what's in the account. However, you can wait to start the reimbursement process for services incurred after you enrolled in your HSA until you have more funds in your account. You can also set up recurring payments for larger expenses as the HSA is funded.

Q: Are dental and vision care considered qualified medical expenses for the purposes of an HSA?

A: Yes, many dental, orthodontia, and eye care expenses are considered qualified medical expenses. However, cosmetic procedures, such as cosmetic dentistry, are not be considered a qualified medical expense. For a detailed list, please use the QME tool at qme.anthem.com

Q: How can I find out more about HSA regulations?

A: Go to the U.S. Treasury website at treasury.gov and enter HSA in the search box. You may also read [IRS Publication 969](#).¹

Q: I am enrolled in a health reimbursement account (HRA). What happens to that money if I choose an HSA for 2026?

A: You will lose any unused funds in your HRA account if you don't use them for services you receive while enrolled in the HRA during the run-out period decided by your employer. Some employers allow unused funds to be transferred to a separate account. The funds in the separate account will not count toward the annual contribution maximum for HSAs and you cannot use them to pay your medical deductible costs. However, they will be automatically used to lower your coinsurance for healthcare costs you have after you meet your annual deductible.

Q: Are any administrative fees charged to my HSA?

A: Yes, see a [list of standard administrative and other related fees](#) that may be charged to your HSA by your administrator.

Q: Do I have to use funds from my HSA to pay for healthcare costs?

A: No, you may pay out of pocket with after-tax dollars and let your HSA balance grow tax-free.

Q: How does the money I contribute to my HSA help me save on taxes?

A: Any money you contribute to your HSA is (federal) tax-deductible. That means it's not counted as taxable income for the year. If you put \$1,000 into your HSA, your adjusted gross income for the year is reduced by \$1,000, which could lower what you owe for taxes, depending on your tax status.

Tax benefits

Q: What are the tax benefits of an HSA?

A: There are several benefits:

- Contributions to the account are tax-free.
- Any investment and interest earned in your account are (federal) tax-free.
- Withdrawals from the account for qualified medical expenses are (federal) tax-free.
- Depending on the state where you live, you may save on state taxes as well.

Your privacy

Q: Is your website secure?

A: Yes, our customer-only website is secure and password-protected. Your personal information is kept safe using the highest encryption level available.

Q: What is your privacy policy?

A: You can read the Privacy Policy anytime at [anthem.com](https://www.anthem.com).

Do you have additional questions?

Connect with us online at [anthem.com](https://www.anthem.com), or call Member Services at the number on your ID card.

The information included does not constitute legal, tax, or benefit plan design advice. We strongly encourage you to consult with a tax advisor before establishing a health savings account. Any health savings account will be established between the individual account holder and the HSA custodian or trustee. Anthem is responsible for the administration of the health plan, and the custodian is responsible for the administration of the HSA.

1 Internal Revenue Service. Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans (January 6, 2022): [irs.gov/pub/irs-pdf/p969.pdf](https://www.irs.gov/pub/irs-pdf/p969.pdf).

2 Internal Revenue Service. Publication 502, Medical and Dental Expenses (Including the Health Coverage Tax Credit) (January 11, 2022): [irs.gov/pub/irs-pdf/p502.pdf](https://www.irs.gov/pub/irs-pdf/p502.pdf).

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IMPORTANT PLAN NOTICES, DISCLOSURES & LEGAL DOCUMENTS



Diocese
of Toledo

Note to All Employees

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. A separate document will be provided to you that outlines the required disclosures for our employee benefits plan. If you have any questions or need further assistance, please contact your Plan Administrator.

Plan Administrator:

Catholic Diocese of Toledo
Meghan Reed/Director of Human Resources
One Seagate, Suite 2300
Toledo OH 43604
419-244-6711

Name of Group Health Plan: The Diocese of Toledo Health Benefits Trust

If you (and/or) your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 9 in the Notices and Disclosure document for more details.

Notice Regarding Special Enrollment Rights

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

If you are declining coverage 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).

If you have a new dependent as a result of a 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, or placement for adoption. **(Note pre-tax payments may not be made for retroactive coverage due to marriage.)**

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within **60 days** of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact your Plan Administrator (identified at the beginning of this section).

Notice Regarding Women's Health and Cancer Rights Act (Janet's Law)

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Refer to your benefit materials for specific deductibles and coinsurance that apply.

If you would like more information on WHCRA benefits, please call your Plan Administrator (identified at the beginning of this section).

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request to the Plan Administrator (identified at the beginning of this section).

Health Insurance Marketplace Coverage Options and Your Health Coverage

To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.5% (indexed annually) of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.5% (indexed annually) of the employee's household income. (An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution - as well as your employee contribution to employment-based coverage - is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

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

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan.

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your Plan Administrator (identified at the beginning of this section)..

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - Cover emergency services by out-of-network providers.

- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, or for more information about your rights under Federal law, contact the Center for Medicare & Medicaid Services at <https://www.cms.gov/nosurprises/consumers>. The federal phone number for information and complaints is: 1-800-985-3059

In addition to federal law, you may have protections available to you through state law. If state law protection is available, contact information will be included on your Explanation of Benefits (EOB) for any applicable services.

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	FLORIDA – Medicaid
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

<p align="center">GEORGIA – Medicaid</p> <p>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</p>	<p align="center">INDIANA – Medicaid</p> <p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
<p align="center">IOWA – Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562</p>	<p align="center">KANSAS – Medicaid</p> <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
<p align="center">KENTUCKY – Medicaid</p> <p>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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p align="center">LOUISIANA – Medicaid</p> <p>Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084</p>
<p align="center">MAINE – Medicaid</p> <p>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/ofl/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218</p>

	Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	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	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	WYOMING – Medicaid

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269
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To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Turning Age 65 and Becoming Medicare Eligible

If you are an active employee and have reached the age of 65, you may be wondering about Medicare. If you are already receiving Social Security benefits, you should receive an advisory notice from Medicare about three (3) months before your 65th birthday for your initial enrollment period. Otherwise, you must actively enroll in Medicare yourself by contacting your local Social Security office as you will not receive a mailed notice of eligibility.

If you are turning age 65 during the plan year but will continue working in a benefits-eligible position, you have the option of enrolling in Medicare Part A (hospital) coverage, which is typically premium-free. You may also enroll in Part B (medical) coverage and Part D (prescription drug) coverage at your cost. If you do enroll in Medicare, this plan and Medicare will coordinate benefits with one plan paying as primary and the other paying as secondary, as determined by Federal law. When Medicare is primary, some carriers require the participant enroll in Medicare Part B; members should call their medical carrier member services line to identify when this is required.

For additional information on Medicare eligibility and enrollment periods, please visit www.Medicare.gov.

Medicare Part D Coverage Notice – Important Information About Your Prescription Drug Coverage and Medicare

Please note that the following notice only applies to individuals who are or will become eligible for Medicare in the next 12 months.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to end-stage renal disease (ESRD)

You are responsible for providing this notice to your spouse, your domestic partner or any dependent who is or will become Medicare eligible in the next 12 months. If your spouse, your domestic partner, or any dependent resides at a different address than you, please contact us to provide that individual's address as soon as possible.

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 Group Health Plan (as identified at the beginning of this section) 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 prescription drug coverage offered by the Group 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 15 through December 7. 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 coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health Plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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 through the Group Health Plan 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 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact your Plan Administrator (identified at the beginning of this section). You will receive this notice each year and again if this coverage through your company 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 U.S. Social Security on the web at www.socialsecurity.gov or call 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).

Notice of Rescission of Coverage

Under Health Care Reform, your coverage may be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation regarding health benefits or due to failure to pay premiums. A 30-day advance notice will be provided before coverage can be rescinded.

Summary of Benefits & Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Summary of Benefits & Coverage (SBC) is a document intended to help people understand their health coverage and compare health plans when shopping for coverage. The federal government requires all healthcare insurers and group healthcare sponsors to provide this document to plan participants. SBCs will be created for each medical plan offered. Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan. The SBC includes:

- A summary of the services covered by the plan
- A summary of the services not covered by the plan
- A glossary of terms commonly used in health insurance
- The copays and/or deductibles required by the plan, but not the premium
- Information about members' rights to continue coverage
- Information about members' appeal rights
- Examples of how the plan will pay for certain services

The SBCs are available electronically. A paper copy is also available, free of charge, by contacting your Plan Administrator (identified at the beginning of this section).