Your Benefits
Health Vitality Finance

2019-2020 Enrollment Guide

Partners in Value

At the Archdiocese of Cincinnati, we do all we can to mitigate the effect of rising healthcare costs. We look at the design of our benefit programs, the providers we work with and the role you can play in keeping our plans affordable. We're asking you to partner with us to control costs by learning about your coverage and how to use it most effectively. The Archdiocese of Cincinnati provides you with a number of tools and resources, but it's up to you to stay informed, make the right choices and then make the most of the benefits you have.

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Welcome to Open Enrollment

In this guide you will find an overview of the benefits available to you through The Archdiocese of Cincinnati (AOC). Open Enrollment will take place between April 30 - May 13, 2019.

Be sure to read your guide carefully to help you decide what level of protection best meets your needs and to ensure a smooth enrollment process.

The only time outside of open enrollment that an employee can **add/drop or make changes** to their coverage is when a qualifying event is experienced such as a marriage/ divorce, birth/adoption, loss/gain eligibility, loss of other coverage, etc., your local administrator has been notified within 30 days of that qualifying event, and the qualifying life event is initiated in MyEnroll. For further details refer to the Summary Document online at benefits.catholiccincinnati.org.

Steps to Enroll

Step 1: Review your benefits package and understand the plans available to you.

Step 2: Gather proof documents for new dependents. Scan in necessary proof documents and save the documents to your desktop as **one PDF per dependent**.

- *You will need to submit these during the online enrollment process by attaching the scanned documents to your MyEnroll file when prompted.*
  You can also fax your proof documents to 1.888.265.2144

Step 3: Enroll

- Log on to www.myenroll.com using your User Name and password**
- Select the red "Enroll" button drop down and select "Enrollment wizard" to access your open enrollment
- When prompted, submit the necessary proof documents for new dependents
- Review the summary and signature page and click Accept and Finalize

MyEnroll Customer Service Contact Information:
1.866.694.6423
AOCBenefits@basusa.com

***If you haven't previously logged into MyEnroll or forgot your username/password, go to www.myenroll.com and click on the "First Time Users" under the Sign-in button and follow through the screens. Please reach out to MyEnroll customer service If you have any issues retrieving a password*

The Archdiocese of Cincinnati Healthcare Plan fully complies with the ethical and religious directives of the United States Conference of Catholic Bishops.

Effective December 31, 2016, the Archdiocese of Cincinnati terminated its Supplemental Retiree Health Insurance Plan and Retiree Dental Plan for Post-65 lay retirees. Effective September 1, 2016, the Pre-65 Retiree Health Plan and Pre-65 Retiree Dental Plan were frozen and no longer accept any new participants.

The Archdiocese of Cincinnati reserves the right, in its sole discretion, to amend, modify, or terminate the Plan at any time and for any reason.

Eligibility Coverage

For active employees and their dependents who are deemed eligible for benefits as outlined below, benefits will begin the first of the month following the employee's date of hire.

Employee Eligibility for Medical, Dental and FSA Plans

- *Full-time employees who work 30+ hours per week or teach 15+ classroom hours per week.*
- *Variable-hour employees who have worked an average of 30+ hours per week or have taught an average of 15+ classroom hours per week during the prior 12-month measurement period.*
- *Teachers who are employed by Athenaeum of Ohio and teach 14+ semester hours per year (or have taught an average of 14+ semester hours per year during the prior 12-month measurement period for variable hour teachers).*

Employee Eligibility for Life, AD&D and Long-Term Disability Insurance

- *All employees who are scheduled to work 20+ hours per week or teach 12+ classroom hours per week.*
- *Teachers who are employed by Athenaeum of Ohio and teach 9+ semester hours per year (or have taught an average of 9+ semester hours per year during the prior 12-month measurement period for variable hour teachers).*

Eligible Dependents*

The plan allows coverage for your legal opposite-sex spouse and/or your child(ren) (biological, adopted, step or foster) from birth to the end of the month that your child attains age 26.

**Eligible spouses and dependent children may select the AOC Healthcare Plan even if the spouse has access to group medical insurance coverage as an employee or the child has access to group medical insurance coverage available through the employer of another parent. Your location administrator will request you to complete an Affidavit of Spouse/Dependent Children Eligibility form. In this case, however, the AOC will require the employee to pay 100% of the cost of the spouse or dependent coverage. Refer to page 4 for additional details on cost.*

Eligible Seminarians

To be eligible for medical benefits and prescription drug coverage, seminarians must be enrolled full-time in the Priestly Formation Program of the Archdiocese of Cincinnati. Coverage begins the first day of the month following the beginning of studies.

Required Proof Documents for Dependent Coverages**

Legal Opposite Sex Marriage

One of the following:

- *Marriage certificate*
- *Federal income tax return*

Biological Child

One of the following:

- *Birth certificate of biological child*
- *Documentation on hospital letterhead indicating the birth date of child(ren) under 6 months old*
- *Federal income tax return*

Adopted Child

One of the following:

- *Official court/agency papers (initial stage)*
- *Official Court Adoption Agreement (mid-stage)*
- *Birth certificate (final stage)*
- *Federal income tax return*

Foster Child

- *Official court or agency placement papers*

Stepchild

All of the following:

- *Child's birth certificate showing the child's parent is the employee's spouse*
- *Marriage certificate showing legal marriage between the employee and the child's parent*
- *Court document showing that the employee's spouse has custody of the child or is required to cover child*

Other Child

- *Court papers demonstrating legal guardianship, including the person named as legal guardian*

Court-Ordered Medical Coverage

One of the following:

- *Qualified Medical Child Support Order (QMCSO)*
- *National Medical Support Notice (NMSN)*

***When adding a new baby to the plan, you must call BAS, within 30 days of the birth, with the Social Security Number to ensure that Anthem does not drop the baby's coverage.*

Medical Benefits

Anthem

Our medical plan is with Anthem. Please reference Anthem's Guide to Using Your Anthem BlueCross & BlueShield Health Plan posted online at benefits.catholiccincinnati.org

- *Summary of Benefits — a detailed description of your coverage*
- *Understanding online tools available to you — register at www.anthem.com*
- *Understanding preventive care services — a detailed list*

Premium Rates and Contributions for 2019/2020 Plan Year

The Archdiocese offers a comprehensive benefits package to employees and their families. With healthcare costs escalating year after year, the Archdiocese strives to provide the best possible coverage at affordable prices. Effective July 1, 2019, the health plan rates will increase approximately 2% for the 2019/2020 plan year. This nominal increase is possible due to the Archdiocese's continued efforts to proactively manage the expenses of the plan.

Monthly			
	Total Cost	*Employer Contribution*	*Employee Contribution*
Single	*$690*	*$656*	*$34*
Family	*$1,607*	*$1,527*	*$80*

Annual			
	Total Cost	*Employer Contribution*	*Employee Contribution*
Single	*$8,280*	*$7,872*	*$408*
Family	*$19,284*	*$18,324*	*$960*

**** Dependent Surcharge**: Any eligible spouse or child may participate in the Archdiocese of Cincinnati Healthcare Plan. However, there is a surcharge related to the cost of covering any spouse or child that is able to be covered under any employer group health plan available to the spouse and/or the child's other parent. The surcharge equals the difference between the "Total Cost" of Single and Family coverage as provided above.*

Example: $1,607 - $690 = $917 and $917 + $34 = $951
$951 cost to employee per month if dependent surcharge applies

	In-Network	*Out of Network*
Plan Payment Levels		
Annual deductible (Individual / Family)	*$480 / $960*	*$960 / $1,920*
Coinsurance – AOC pays	*80%*	*60%*
Annual out-of-pocket limit (Individual / Family)	*$2,480 / $4,960*	*$3,720/ $7,440*
Physician Services		
Preventive Visits	*100%*	*60%*
Primary Care Physician office visits	*$25 copay*	*60%*
Specialist Physician's office visits	*$35 copay*	*60%*
Online LiveHealth Physician visits	*$10 copay*	*N/A*
Inpatient Hospital – Facility Services		
Inpatient hospitalization and facility services	*80%*	*60%*
Outpatient Care		
Operating room, recovery room, procedure room and treatment services	*80%*	*60%*
Emergency/Urgent Care		
Hospital emergency room, Not Admitted	*80%*	*80%*
Hospital emergency room, Admitted	*Charges Waived*	*Charges Waived*
Ambulance services	*80%*	*80%*

Online and Mobile Access

Find providers, view ID cards, and much more at www.anthem.com via the web or free mobile app.

1. Go to anthem.com and select "Register Now"
2. Provide the personal information requested
3. Create a username and password
4. Set your email preferences
5. Select submit

1. Search for Anthem Blue Cross and Blue Shield in your app store and select Install
2. Open the app and select Register Now
3. Confirm your identity
4. Create a username and password
5. Set your email preferences Confirm and select Register

Find a Provider

If you're a member:

1. Go to www.anthem.com and log in, or use your ID number to search without logging in. Scroll down the page and select Find a Doctor.
2. Next, select a type of provider, place or name. Select Search.
3. Select a provider for more information

If you're not a member yet:

1. Go to www.anthem.com. Scroll down the page and select Find a Doctor. Under Search as Guest, click Search by Selecting Plan or Network.
2. Select "Medical" then choose your state and select the Blue Access Network. Next, select a type of provider, place or name. Select Search.
3. Select a provider for more information

Know before you go—use Anthem's Estimate our cost tool!

The Estimate Your Cost tool allows you to compare costs for nearly 40 medical procedures like MRIs and CT scans from doctors and hospitals in your area. The tool also shows performance and safety ratings.

To get started:

1. Register and log in to www.anthem.com
2. On your Account Summary landing page, look for the Estimate Your Cost tool on the right side
3. Click on Start Cost Search
4. On the Estimate Your Cost page, choose options from the drop-down menus to start comparing

Why is Anthem Calling Me?

We care about your health, so you might get a confidential call from Anthem.

Anthem calls with your best interest at heart. Anthem can call for a variety of reasons. Some- times they'll call to offer to help you with health issues, such as losing weight, quitting smoking, preparing for surgery or making healthier life choices. Other times, they'll call to give you important health reminders. If you're expecting a baby, they might introduce you to a supportive program that can help you enjoy a healthier pregnancy. Best of all, these programs have no extra cost, and Anthem will always explain how they work with your benefits.

Keep in mind:

- These calls are always confidential, so you can feel comfortable talking with Anthem.
- Anthem is not calling to "sell" anything. They only call when they identify an area where they can help. The suggestions or programs they'll recommend are already included in your health benefits.
- You will be asked to verify your name and date of birth. That's because Anthem wants to make sure they're speaking to the right person before we discuss your health. It's a way to protect your personal health information.

Advanced Imaging

MRI, MRA, PET, CT non-maternity ultrasound and nuclear cardiology

Here's how the program works:

If your doctor determines you are in need of one of the advanced imaging scans noted above, he/she will contact Anthem to initiate the pre-authorization process.

Anthem will review the referred imaging provider to confirm they offer the best quality of care and price in your area. If another provider in your area is recommended, this will be handled with your doctor during the pre-authorization process and you will be directed accordingly by your doctor. If your doctor chooses not to refer you to the preferred facility, Anthem will contact you to let you know of the preferred choices in your area.

Should your doctor fail to obtain the pre-authorization, your claim cost will not be impacted.

LiveHealth Online

www.livehealthonline.com or free mobile app LiveHealth Online allows you to live chat with your choice of a board-certified doctor 24/7, 365 days a year. LiveHealth Online doctors are able to answer questions, provide diagnosis of conditions such as cold and flu, allergies, sinus infections and more and prescribe basic medications when needed. And the cost of the appointment is $10!

LiveHealth Online Psychology allows you to speak face-to-face with a licensed therapist or psychologist using your smartphone, tablet or webcam. Appointments are available within just a few days, offering flexibility during daytime, evenings and weekends. LiveHealth Online Psychology visits are also covered by a $10 copay!

Scan the QR code provided here with your iPhone to be automatically

Scan the QR code provided here with your Android smartphone to be automatically

Employee Assistance Program (EAP)

800.999.7222

Planning for life events such as arranging for daycare or caring for aging parents, dealing with finances, or personal and relationship issues may impact your work, health and family. The Anthem Employee Assistance Program (EAP) provides support, resources and information for personal work-life issues. This service is company-sponsored, confidential and provided at no charge to you and your dependents.

Visit anthemEAP.com and enter the code AOC to learn about all of the services and resources they provide.

24/7 Nurseline

888.249.3820

Call the 24/7 Nurseline to talk with a registered nurse about your health concern, whether it be allergies, fever, types of preventive care, or other topics. The nurses are able to help you determine if you need to seek care, and if so, the urgency. Spanish speaking nurses and translators are available.

If you prefer not to speak to a nurse, you can access the AudioHealth library of prerecorded messages on more than 300 different health topics in both English and Spanish. You can access these messages by calling the Nurseline and selecting the option for the AudioHealth library.

ConditionCare

888.249.3820

The ConditionCare nurse managers can help with controlling the following ongoing conditions: asthma, COPD, coronary artery disease, diabetes and heart failure. The nurse managers are trained in these conditions to work with both children and adults. They can help you better manage your condition through education about the condition and symptoms and how to properly and effectively follow your medication instructions and treatment plan.

Future Moms

888.249.3820

Future Moms helps expectant mothers get the care they need and make healthy choices. Nurse coaches are available to answer questions, provide educational booklets, and assess and manage risks, among other things.

Prescription Drugs
Optum Rx – Value Network

IMPORTANT:
Your OptumRx prescription benefit is separate from your Anthem medical benefit and is accessed using a separate OptumRx ID card

Prescriptions can be confusing.
To help you navigate your prescription drug plan and save money, the Archdiocese of Cincinnati has implemented the following programs:

Generic Drugs
Generic drugs must be dispensed when available. If a member prefers to obtain the non-formulary brand product, member will pay brand copay PLUS the difference in cost between the brand and the generic product.

If there is medical justification for the use of brand vs. generic, the physician may call in a request for prior authorization to be reviewed by the Prior Authorization department.

	Retail-30 days	Mail Order-90 days
Generic	$10	$25
Formulary	$30	$75
Non-Formulary	$60	$150

- *Formulary brand refers to brand drugs with no generic available.*
- *Non-formulary brand primarily refers to brand drugs that have other alternatives available.*

Prior Authorization
If you are prescribed one of the medications that require prior authorization, you will be notified after you fill your first prescription. At that time, if you wish to keep using your medication, it must be pre-approved before your benefit plan will continue to cover it. The information needed for the prior authorization review must be submitted to OptumRx by your doctor.

Prior Authorization Process
Your doctor can start the prior authorization review process by contacting the OptumRx Prior Authorization department at 1.800.711.4555. A pharmacy technician then works with your doctor to get the information needed for the review. Once OptumRx receives a completed prior authorization form from your doctor, they will conduct a detailed clinical review within three business days. OptumRx will then send you and your doctor a letter regarding the prior authorization decision.

If you need Specialty Drugs

Specialty Pharmacy
If you are prescribed specialty drugs, the OptumRx specialty pharmacy, BriovaRx, will be your specialty pharmacy. You and your prescriber will be assigned a team to support you throughout the course of your specialty medication therapy.

To help you take full advantage of your enhanced specialty pharmacy program please note:

- Depending on whether your specialty medication is oral or injectable, or your caregiver, doctor, or you administer it, OptumRx/BriovaRx can deliver your order to your physician's office or to your home. Shipping is at no charge to you.
- Your plan will cover up to a 30-day supply of your specialty medications at your plan's applicable copayment.

Questions about prescriptions?
Contact OptumRx Customer Service at
1.800.797.9791 or visit www.optumrx.com to:

- View your claim history
- Check status of mail orders
- Find network retail pharmacies
- Refill scripts through mail service pharmacy

Scan nth QR code provided here with your smartphone to be automatically directed to www.optumrx.com

Flexible Spending Account (FSA)
Benefit Allocation Systems (BAS)

What is it?

Flexible Spending Accounts (FSAs) allow you to pay for eligible health care and dependent care expenses using pre-tax dollars. The money deposited into your spending account is deducted from your paycheck before taxes are withheld, which lowers your taxable income. You are only able to carryover up to $500 to the next year, so plan carefully. The example below* shows the savings an FSA provides.

How much can I save on taxes?

	Your paycheck without a FSA	Your paycheck with a FSA
Gross Salary	$1,500	$1,500
FSA Contribution	$0	$200
Adjusted Salary	$1,500	$1,300
Income Tax	($450)	($390)
Net Salary	$1,050	$910
Out-of-pocket Healthcare Cost	$200	$0 (used their FSA)
Remaining Pay	$850	$910

You can have a healthcare FSA and a dependent care FSA, but you can only use money in the health- care FSA for healthcare expenses, and you can only use money in the dependent care FSA for child or adult day care expenses.

What can I use it on?

Allowable healthcare expenses include deductibles, copays, prescriptions, labs, x-rays, vision/dental expenses to name a few. Dependent care expenses include preschool, before/after school care, summer camps, and adult or child day care.

How does it work?

If you decide to contribute to a healthcare FSA, you will receive a Benny card in the mail. The Benny card is similar to a debit card and is linked directly to your FSA. You should always save your receipts when you have used the Benny card, as you will need to **SUBSTANTIATE** the charge. To substantiate means to provide proof that the purchase was an eligible expense.

If you pay for an expense without the Benny card, you can request reimbursement from your FSA. To do so, you submit a claim to BAS by filling out necessary forms and providing required substantiation (receipts, invoices, etc.).

The dependent care FSA does not have a Benny card. All expenses are paid by the employee and then you can submit a claim for reimbursement from your account.

How much should I elect to contribute?

Deciding how much to fund your flexible savings account can seem intimidating. A good rule of thumb is to take a close look at your healthcare or child care expenses over the last 12-18 months, such as prescription drugs, doctor's visits, eyeglasses, deductibles and copayments, to help you decide the amount to set aside in your FSA.

Account Type	*Use it for:*	*How much can I contribute for 2019?*	*Does it rollover?*	
Health Care FSA	***Medical, dental, and vision expenses***	***$2,700 (minimum is $240)***	***You can rollover up to $500 to the next plan year***	
Dependent Care FSA	***Dependent care for children under the age of 13 or a disabled spouse or parent***	***Annual Maximum Contribution = $5,000 per couple for married filing jointly and single head of household or $2,500 per individual for married filing separately***	***No***	

Important Note: *Should your employment terminate, your FSA participation will end on your last day of employment. Per the Internal Revenue Code, any funds remaining in your account, against which claims have not been incurred by or prior to your date of termination, will be forfeited.*

**The chart above is hypothetical and is for illustrative purposes only. The information has been made available to you as self-help tool for your independent use and is not intended to provide financial advice. Gallagher and the AOC do not guarantee the applicability or accuracy in regards to your individual circumstances.*

Voluntary Dental

Dental Care Plus

There are two dental plans to choose from. They are both 100% paid by the employee. They both have the same level of care and coverage. **What distinguishes one program from the other is cost and flexibility**.

Dental HMO Plan— Lower monthly premium and a large selection of dentists from which to choose. Members need to select and receive treatment from a participating dentist in order to receive benefits. Select this plan if your dentist is in the Dental Care Plus HMO Network or if you are comfortable with selecting a new dentist in the network.

Dental Indemnity Plan— Higher out-of-pocket costs (both in monthly premium and per-visit fees) with additional network flexibility. In the Dental Indemnity Plan, members are responsible for the portion of fees that are not reimbursed by the plan. You may want to select this plan if your current dentist is not in the DHMO Plan network, and you do not want to change dentists.

To find a dentist visit www.dentalcareplus.com or call 1.800.367.9466.

	DHMO Plan	Indemnity Plan
Monthly Employee Cost (single/family)	$27.10/$82.11	$29.92/$85.22
Individual Max/ calendar year	$1,000	$1,000
Annual deductible (Single/family) (Basic and major only)	$50/$150	$50/$150
Percent paid by Dental Care Plus		
Preventive	100%	100%
Basic	50%	50%*
Major	50%	50%*
Child Orthodontia	50%	N/A
Ortho Lifetime Max	$1,000	N/A

*Member will be balance billed for costs exceeding DCP contracted rates

Scan the QR code provided here with your smartphone to be automatically directed to Dental Care Plus.

Total Vision Services

If you enroll in one of the dental plans with DCP, you also have access to a free vision discount program*! You and your covered dependents will be enrolled in one of two programs offered by Total Vision Services (TVS): the TVS product or the Coast to Coast product. Both programs feature discounts with unlimited usage, no paperwork to file and no health restrictions. Your enrollment in the appropriate program is automatic and based on your home ZIP Code.

Total Vision Services Plan
The Total Vision Services Plan enables you and your covered dependents the opportunity to purchase optical goods and services at substantial savings at reputable optical providers. The program provides discounts of 20% to 60% on eyeglasses, contact lenses (excluding disposables) and many other items offered at retail. You will also receive savings of 10% to 30% on medical eye exams and surgical procedures including refractive surgery. Present your Dental Care Plus ID card at any of the provider locations to receive your program discount. If you decide to use your own eye doctor and not take advantage of the reduced examination fees under the TVS product, take your prescription to any of the provider locations and they will fill it for you at TVS product rates.

Coast to Coast
Coast to Coast (CTC) has contracted with more than 12,000 eye care professionals nationwide to provide you and your family a 20% to 30% discount on eyeglasses, contact lenses (excluding disposables) and many other items offered at retail. Discounts of 10% to 30% on eye examinations are available at most participating locations. You can save up to 40% on contact lenses through mail order. Present your ID card prior to service. Should you decide to use your own eye doctor, take your prescription to any of the provider locations to receive the Coast to Coast discount on materials (frames and lenses).

For plan eligibility, discount amounts or to search for a participating provider, visit www.dentalcareplus.com/vision or call (513) 921-7500 or (800) 869-5400.

Hearing Services Program- Epic Hearing Health Care-

If you enroll in one of the dental plans with DCP, you automatically receive access to the hearing services program, administered by EPIC Hearing Health Care. This program provides savings to you and your family on hearing devices, including name-brand hearing aids and batteries.

How this works:
Call (888) 899-1485 to speak with a hearing counselor who will assess your needs and refer you to a provider on EPIC's national network. You can also start the process by visiting www.EpicHearing.com.

*This is not an insurance plan.
**Hearing aid costs will vary based on level of technology.

Basic Life and AD&D Insurance**

The Standard

The Archdiocese of Cincinnati provides its eligible employees with $50,000 of Group Life and $50,000 Accidental Death and Dismemberment (AD&D) insurance.

Features of your Life coverage include a Right to Convert Pro- vision, a Portability of Insurance Provision, Waiver of Premium (which will continue Life coverage without payment of premium while you are totally disabled), and an Accelerated Benefit for the terminally ill.

The Accidental Death and Dismemberment (AD&D) coverage is available in the event of an accidental death or dismemberment, meaning the loss of use of specific body parts or functions such as outlined in your plan booklet.

Long-Term Disability (LTD) Insurance

The Standard

LTD insurance provides income replacement in the amount of 60 percent of the first $8,333 of monthly predisability earnings, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, pension, etc.). The maximum monthly benefit is $5,000 and the minimum monthly benefit is $100. Benefits begin after a benefit waiting period of 180 days.

To be eligible for LTD insurance, for the benefit waiting period and the first 24 months for which LTD benefits are paid, you must be unable, as a result of physical disease, injury, pregnancy or mental disorder, to perform with reasonable continuity the material duties of your own occupation and suffering a loss of at least 20 percent of pre-disability earnings when working in the employee's own occupation. After that, you must be unable as a result of physical disease, injury, pregnancy or mental disorder to perform with reasonable continuity the material duties of any reasonable gainful occupation. You are not considered disabled when earning 80 percent or more of pre-disability earnings in any occupation.

An eligible employee who needs to make a Long-Term Disability claim can do so by notifying his/her Location Administrator, who will help facilitate the process. LTD claims must be approved by The Standard Insurance Company.

Supplemental Life Insurance**

The Standard

The Archdiocese of Cincinnati recognizes that different individuals have varying comfort levels and needs in regards to life insurance. It is important that you analyze a variety of factors to determine where you and your family need expanded cover- age (e.g., risk factors, age, wellness, and medical history).

Eligibility

- Employee — See the Eligibility for Life, AD&D and Long-Term Disability Insurance section on page 4
- Spouse — Employee's legal opposite sex spouse
- Children — Eligible dependent children from live birth to age 26

Benefit

Remember that the Archdiocese of Cincinnati provides you with $50,000 of Life coverage. For additional Group Term Life above the $50,000, employees can elect Supplemental Life Insurance in increments of $10,000 up to $500,000.

The Employee must elect Supplemental Life coverage, in order for him/herself to elect coverage for a spouse/dependent. The spouse coverage amount can be elected in increments of $10,000, not to exceed the employee's benefit amount.

Eligible children may be covered from birth to age 26. You can elect a benefit amount of $2,500, $5,000, $7,500, or $10,000.

If an employee or spouse elects or increases coverage during annual enrollment, an Evidence of Insurability (EOI)* form must be completed and approved by The Standard. This form is available within the MyEnroll system.

**Benefit won't become effective until EOI is approved by The Standard.*

Premium - Monthly

To determine your monthly premium, take your age at your last birthday, find the rate as shown per $10,000 unit of life insurance, and multiply that rate by the number of $10,000 units you desire. Do the same thing for your spouse at his/her age for the number of units requested.

Age	Rate	Age	Rate
Under age 20	$0.63	50–54	$4.63
20–24	$0.75	55–59	$8.00
25–29	$0.88	60–64	$11.00
30–34	$1.13	65–69	$20.75
35–39	$1.50	70–74	$33.50
40–44	$2.00	75–79	$54.25
45–49	$2.88	80+	$87.88

Monthly premium rates are based on your age at your last birth- day. They will change on the plan anniversary date coinciding with or next following your last birthday as you advance to a higher age bracket.

Dependent Child Benefit Amount Selected	Rate (Regardless of # of children)
$2,500	$0.125
$5,000	$0.250
$7,500	$0.375
$10,000	$0.500

***The basic and supplemental life insurance benefits are subject to the following age reduction schedule: reduction by 35% at age 65, 58% at age 70 and 70% at age 75.*

Travel Assistance

The Standard

www.standard.com/travel

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you, your spouse and dependent children up to age 26 navigate these issues and more at any time of the day or night.

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers the following aid both before and during your trip.

- Passport, Visa, weather and currency exchange information, health hazards advice and inoculation requirements
- Emergency ticket, credit card and passport replacement, funds transfer and missing baggage
- 24/7/365 phone access to registered nurses for health and medication information, symptom decision support and help understanding treatment options
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains
- Connection to medical care providers, interpreter services, a local attorney, consular office or bail bond services
- Return travel companion if travel is disrupted due to emergency transportation services or return dependent children if left unattended due to prolonged hospitalization
- Logistical arrangements for ground transportation, housing and/or evacuation in the event of political unrest and social instability; for more complex situations, assistance with making arrangements with providers of specialized security services

Contact Travel Assistance Phone

United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda 800.527.0218
Everywhere else +1.410.453.630

Email
Assistance@uhcglobal.com

When You Retire

Medicare

Medicare and Group Health Plan Coverage
When you retire and are Medicare-eligible, you have a number of important decisions to make. These may include whether to enroll in Medicare Part B, join a Medicare Prescription Drug Plan, or buy a Medigap policy.

Understanding your choices
To help you avoid paying more than you need to for Medicare Part B and other insurance, and get the coverage that's best for you, you can visit www.medicare. gov and select "Compare Medicare Prescription Drug Plans" and "Compare Health Plans and Medigap Policies in Your Area." You can also call your State Health Insurance Assistance Program. To get the telephone number for your state's program, call 1.800. MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

Medicare Part B benefits are optional and are available to all retirees when they become entitled to Medicare Part A. Medicare Part B may be purchased by most persons age
65. Failure to purchase Medicare Part B will drastically affect an individual's ability to recover any costs incurred for physician services and other Medicare Part B covered items.

Medicare Part D (prescriptions)
Those eligible for Medicare are provided a letter of creditable coverage. The letter states that the prescription drug program currently provided by the Archdiocese Healthcare Plan exceeds Medicare Part D. Medicare participants and individuals over age 65 are advised that they could select the Archdiocese of Cincinnati Health- care Plan instead of Medicare Part D if they are still actively employed by the AOC and benefit eligible. The letter permits Medicare eligible persons to join Medicare Part D at a later date, if they choose, without paying a late entrant "penalty." This letter will be provided annually prior to Medicare open enrollment.

RetireMED®iQ is an additional source of information. They are an independent health plan advisory service that offers guidance to individuals in need of insurance options upon retirement. Their goal is to give retirees information and guidance to choose the insurance plan that best meets their retirement budget, needs and life- style - at no cost to the retiree. RetireMED®iQ can be reached at 1.844.388.6565 or www.retiremediq.com.

Contact Information

If you would like to further research your benefit options, find a provider, or ask detailed questions about your benefit coverage, you may contact the insurance companies/service providers directly. Listed below are toll-free phone numbers and websites for those that provide benefits and services to AOC employees.

Benefit	Administrator	Phone	Website/Email
Medical	Anthem	1.800.887.6055	www.anthem.com
Prescription	OptumRx	1.800.797.9791	www.optumrx.com
Life & AD&D/LTD/Voluntary Life	The Standard	Life 1.800.628.8600 LTD: 1.800.368.1135	www.standard.com
Voluntary Dental	Dental Care Plus	1.800.367.9466	www.dentalcareplus.com
Flexible Spending Account(FSA)	BAS	1.866.694.6423	AOCBenefits@basusa.com
Employee Assistance Program (EAP)	Anthem EAP	1.800.999.7222	www.anthemEAP.com, Code: AOC
Benefits Customer Service (MyEnroll)	BAS	1.866.694.6423	AOCBenefits@basusa.com

If you have questions regarding the enrollment process, your payroll deductions, or need general benefit information, please contact MyEnroll or your location administrator.

Scan with your smart phone to be directed to the corresponding vendor.

Scan the QR code provided here with your smartphone to be automatically directed to **www.anthem.com** mobile site.

Scan the QR code provided here with your smartphone to be automatically directed to **www.optumrx.com.**

Scan the QR code provided here with your smartphone to be automatically directed **to Dental Care Plus**

AOC Benefits Website

At home or on the road you can go to:
benefits.catholiccincinnati.org

Find a wealth of information about your benefits and explore helpful decision-making tools.

Here's just a small sampling of what you'll find:

- Open enrollment information
- Benefit plan information
- Links to providers such as Anthem, OptumRx, BAS
- Helpful decision-making tools
- Health news
- Explanations of government benefits
- Find specific information and summaries of the benefits offered by the Archdiocese of Cincinnati

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice.

This document is an outline of the coverage and services provided by the carrier(s) or vendor(s). It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details and are available for your reference through Archdiocese of Cincinnati or upon request.

Legal Notices

Grandfathered Health Plan under the Patient Protection and Affordable Care Act

The Archdiocese of Cincinnati Health and Welfare Plan (the "Plan") has maintained a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866.444.3272 or www.dol.gov/ebsa/healthcarereform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Rescission of Coverage

Beginning with Plan Years starting on or after September 23, 2010, a grandfathered plan may rescind coverage only under limited circumstances (such as in the case of fraud or an intentional misrepresentation of fact). This applies to a cancellation or discontinuation of coverage that has retroactive effect (unless the cancellation is effective retroactively due to a failure to timely pay premiums). A grandfathered health plan must provide at least 30 calendar days' advance notice to an enrollee coverage may be rescinded.

Rules Limiting Reimbursement for Over- the- Counter Medications

Effective for expenses incurred beginning in 2011, health FSAs, (including grandfathered plans) may not reimburse participants for the cost of medication unless the medication is a prescribed drug or insulin, and thus may not reimburse costs of most over-the-counter medications.

Women's Health & Cancer Rights Act (WHCRA)

Federal and State legislation require group health plans and health insurers provide coverage for reconstructive surgery following a mastectomy. Specifically, these laws state that health plans that cover mastectomies must also provide coverage in a manner determined in consultation with the attending physician and patient for:

» Reconstruction of the breast on which the mastectomy has been performed;

» Surgery and reconstruction of the other breast to produce a symmetrical appearance, and;

» Prostheses and treatment for physical complications for all stages of mastectomy, including lymphedemas.

The Newborns' Act

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

The Newborns' Act, and its regulations, prohibit incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

Military Leave Employees

Continuation of Coverage Due to Military Service In the event you are no longer Actively at Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"Military Service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible dependents (if any) under the Plan by notifying your employer in advance and payment of any required contribution for health coverage. This may include the amount the Employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active member contribution for continuation of health coverage.

If continuation is elected under this provision, the maximum period of health coverage under the Plan shall be the lesser of:

- The 24-month period beginning on the first date of your absence from work; or
- The day after the date on which you fail to apply for or return to a position of employment

Regardless whether you continue your health coverage, if you return to your position of employment, your health coverage and that of your eligible dependents (if any) will be reinstated under the Plan. No exclusions or waiting period may be imposed on you or your eligible dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Health Insurance Portability & Accountability Act (HIPAA)

Enrollment Rights under the Health Insurance Portability and Accountability ACT (HIPAA)

If you are declining enrollment for yourself or your dependents (including your spouse or child(ren)) because of other health insurance, you may be able to enroll yourself and your dependents in an Archdiocese of Cincinnati plan if you or your dependents lose eligibility for that other coverage. You must request enrollment within 31 days of the date the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days of the date the other coverage ends.

Notice of Availability

This notice describes how you may obtain a copy of the Plan's Notice of Privacy Practices, which describes the ways that the Plan uses and discloses your protected health information (PHI). The Archdiocese of Cincinnati provides health benefits to eligible employees and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses PHI.

Children's Health Insurance Program Reauthorization Act

New Special Enrollment Period for Health Coverage

Eligible employees and their dependents may enroll in the Archdiocese of Cincinnati health coverage at time of hire, during open enrollment or when they experience a qualifying event such as marriage, birth of a child or loss of other coverage.

The group health plans provided by Archdiocese of Cincinnati include two additional special enrollment opportunities. These two qualifying events are when:

1. The employee or dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
2. The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

An employee must request this special enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. Thirty-day notice is required for all other special enrollments.

Should you have a qualifying event and want to enroll in health coverage, contact your location administrator. 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.

Notice of Creditable Prescription Drug Coverage If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

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 Archdiocese of Cincinnati 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. 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.

Individuals can enroll in a Medicare drug plan when you first become eligible, and each year from October 15 through December 7. If you lose your current creditable prescription drug coverage or decide to leave the Archdiocese of Cincinnati you may be eligible for a Medicare Special Enrollment Period. Archdiocese of Cincinnati has determined that the prescription drug coverage offered by the Notice of Archdiocese of Cincinnati Health Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage. Because Archdiocese of Cincinnati's coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you decide to join a Medicare drug plan and you are an active employee or family member of an active employee, you may also continue your Archdiocese of Cincinnati coverage. In this case, the Archdiocese of Cincinnati plan will continue to pay primary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Archdiocese of Cincinnati coverage, Medicare will be your only payer. Active employees can re-enroll in the Archdiocese of Cincinnati Healthcare Plan at annual enrollment or if you have a special enrollment event.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if the Archdiocese of Cincinnati coverage changes or upon request.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. Medicare participants will get a copy of this handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. Here's how to get more information about Medicare drug coverage.

You should know that if you waive or leave coverage with the Archdiocese of Cincinnati and you go 63 continuous days or longer without creditable prescription drug coverage (once the applicable Medicare enrollment period ends), your monthly Part D premium may go up by at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. 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.

Visit www.medicare.gov for personalized help.

» Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number).

» 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 whether or not you are required to pay a higher premium (a penalty).

For more information about this notice or your prescription drug coverage, please contact:

Name of Entity: Archdiocese of Cincinnati

Contact: Charlotte Carpenter

Address: 100 East Eighth Street, Cincinnati OH 45202

Phone Number: 513-421-3131

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 on pages 6-7, 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 31st, 2019. Contact your State for more information on eligibility

ALABAMA - MEDICAID	FLORIDA - MEDICAID
Website: http://myalhipp.com/ **Phone:** 1-855-692-5447	**Website:** http://flmedicaidtplrecovery.com/hipp/ **Phone:** 1-877-357-3268
ALASKA - MEDICAID	**GEORGIA - MEDICAID**
The AK Health Insurance Premium Payment Program **Website:** http://myakhipp.com/ **Phone:** 1-866-251-4861 **E-mail:** CustomerService@MyAKHIPP.com **Medicaid Eligibility:** http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	**Website: Medicaid** www.medicaid.georgia.gov -Click on Health Insurance Premium Payment (HIPP) **Phone:** 1-404-656-4507
ARKANSAS - MEDICAID	**INDIANA - MEDICAID**
Website: http://myarhipp.com/ **Phone:** 1-855-MyARHIPP (1-855-692-7447)	Healthy Indiana Plan for low-income adults (age 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
IOWA - MEDICAID	**KANSAS - MEDICAID**
Website: http://dhs.iowa.gov/hawk-i **Phone:** 1-800-257-8563	**Website:** http://www.kdheks.gov/hcf/ **Phone:** 1-785-296-3512
KENTUCKY - MEDICAID	**NEW HAMPSHIRE - MEDICAID**
Website: http://chfs.ky.gov/ **Phone:** 1-800-635-2570	**Website:** http://www.dhhs.nh.gov/oii/hipp.htm **Phone:** 1-603-271-5218 **Toll-Free:** 1-800-852-3345, ext. 5218
LOUISIANA - MEDICAID	**NEW JERSEY - MEDICAID & CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 **Phone:** 1-888-695-2447	**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

MAINE - MEDICAID	NEW YORK - MEDICAID
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html **Phone:** 1-800-442-6003 **TTY:** Maine Relay 711	**Website:** https://www.health.ny.gov/health_care/medicaid/ **Phone:** 1-800-541-2831
MASSACHUSETTS - MEDICAID & CHIP	**NORTH CAROLINA - MEDICAID**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ **Phone:** 1-800-862-4840	**Website:** https://dma.ncdhhs.gov/ **Phone:** 1-919-855-4100
MINNESOTA - MEDICAID	**NORTH DAKOTA - MEDICAID**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp **Phone:** 1-800-657-3739 or 1-651-431-2670	**Website:** http://www.nd.gov/dhs/services/medicalserv/medicaid/ **Phone:** 1-844-854-4825
MISSOURI - MEDICAID	**OKLAHOMA - MEDICAID & CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm **Phone:** 1-573-751-2005	**Website:** http://www.insureoklahoma.org **Phone:** 1-888-365-3742
MONTANA - MEDICAID	**OREGON - MEDICAID & CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP **Phone:** 1-800-694-3084	**Website:** http://healthcare.oregon.gov/Pages/index.aspx & http://www.oregonhealthcare.gov/index-es.html **Phone:** 1-800-699-9075
NEBRASKA - MEDICAID	**PENNSYLVANIA - MEDICAID**
Website: http://www.ACCESSNebraska.ne.gov **Phone:** 855-632-7633 **Lincoln:** 402-473-7000 **Omaha:** 402-595-1178	**Website:** http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm **Phone:** 1-800-692-7462
NEVADA - MEDICAID	**RHODE ISLAND - MEDICAID**
Medicaid Website: https://dwss.nv.gov/ **Phone:** 1-800-992-0900	**Website:** http://www.eohhs.ri.gov/ **Phone:** 1-401-462-5300
SOUTH CAROLINA - MEDICAID	**VIRGINIA - MEDICAID & CHIP**
Website: https://www.scdhhs.gov **Phone:** 1-888-549-0820	**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
SOUTH DAKOTA - MEDICAID	**WASHINGTON - MEDICAID**
Website: http://dss.sd.gov **Phone:** 1-888-828-0059	**Website:** http://www.hca.wa.gov/free-or-low-cost-healthcare/program-administration/premium-payment-program **Phone:** 1-800-562-3022 ext. 15473
TEXAS - MEDICAID	**WEST VIRGINIA - MEDICAID**
Website: http://gethipptexas.com/ **Phone:** 1-800-440-0493	**Website:** http://mywvhipp.com **Phone:** 1-855-MyWVHIPP (1-855-699-8447)

UTAH - MEDICAID & CHIP	WISCONSIN - MEDICAID & CHIP
Medicaid Website: https://medicaid.utah.gov/ **CHIP Website:** http://health.utah.gov/chip **Phone:** 1-877-543-7669	**Website:** https://www.dhs.wisconsin.gov publications/p1/p10095.pdf **Phone:** 1-800-362-3002
VERMONT - MEDICAID	**WYOMING - MEDICAID**
Website: http://www.greenmountaincare.org/ **Phone:** 1-800-250-8427	**Website:** https://health.wyo.gov/healthcarefin/medicaid/ **Phone:** 1-307-777-7531

To see if any other states have added a premium assistance program since January 31st, 2019 or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare and Medicaid Services

www.cms.hhs.gov

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.