

*Kathleen Ferguson*  
*Human Resources Director*



## CITY OF MANCHESTER Human Resources Department

### FY 2021 Acknowledgement Letter

I understand I need to meet the following deductible effective July 1, 2020 before all of my in-network costs are covered at 100% for the plan year 7/1/2020-6/30/2021:

\$ 2,000 for a 1 person plan

\$ 4,000 for a family plan (*a family consists of 2 or more individuals*)

I understand the City of Manchester will fund my HSA for the plan year 7/1/2019-6/30/2020 as follows:

- 1 person plan \$1,500 total (\$ 750 in July 2020 and \$150 for the next 5 months)
- Family plan \$3,000 total (\$1,500 in July 2020 and \$300 for the next 5 months)

I may elect at any time to close my HSA by contacting the HSA Custodian. However if I do elect to close my HSA account, the City will be unable to make the City Contribution.

**\*\*New Employees\*\*** Please be aware that if you are enrolling in the H S A plan outside of open enrollment, the City will prorate the amount funded into your H S A based on the number of months remaining in the first plan year of your employment: \$125.00/month Single; \$250/month Family. Please note, the annual deductible will not be prorated.

### HSA Requirements

- By enrolling in the HDHP, I understand that BenefitWallet will automatically open an HSA account on my behalf.
- I understand I or any family member covered by my plan cannot have an FSA (Health Flexible Spending Account).
- I and my covered family members are not covered under any other medical plan that is not an HSA – compatible health plan.
- I am not enrolled in Medicare Part A nor Medicare Part A and B.
- I am aware that I can only use my HSA funds for my spouse and eligible dependents. (Eligible dependents are dependents you claim on your tax return.)
- I am not eligible to be claimed as a dependent on another individual's tax return.
- I am a US resident and not a resident of Puerto Rico or American Samoa nor are any covered dependents.
- I have not received any veteran's benefits within the last 3 months nor have any covered dependents.

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Signature

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Date

I understand that checking this box constitutes a legal signature confirming that I acknowledge the information on this form.