

City of Greensburg

Employee Benefits 2024

Highlights and Summary

(Including required annual notices)

The following will be offered to the City of Greensburg employees and their eligible dependents as of January 1, 2024. This Medical - Schedule of Benefits includes the benefits available, coverage amounts and maximum amounts that apply under the Plan. However, Plan payment is not based solely on the Schedule of Benefits. For a complete understanding of whether a particular charge will be paid and at what level, all provisions outlined in this document must be reviewed. Refer to Summary Plan Description (SPD) for specific details. The SPD is the authoritative document over this brief summary of benefits.

OPEN ENROLLMENT

You play an imperative part in the plans victory. That's why every attempt has been made to make available the best benefits program that compensates you for the hard work you put forth. Benefits are an important part of your total compensation package. This guide provides information to help you better understand your health plan and benefits. During open enrollment period you have the chance to review your needs, review the benefits available to you and make selections that are most valuable to you. Open enrollment is your chance to make changes to your benefit enrollments. The benefits you choose during this time will be effective **January 1, 2024**.

Enrollment will be open November 13 to November 17, 2023.

Note: you may also change your coverage during the year if you have a qualifying event. This includes but is not limited to loss of coverage, death, marriage, birth, divorce, or adoption. For any allowable change you must notify your Employer/Group Health Plan within 30 calendar days of the event and provide proof of the event, or you must wait until the next open enrollment to make changes.

ELIGIBILITY

All full-time salaried and hourly employees will be eligible for coverage. Full-time is defined as employees who are scheduled to work at least 30 hours per week at the usual place of business or the location which you are required to travel. Seasonal and/or temporary employees are not eligible for coverage under this Plan. No person may be covered both as an Employee and a Dependent of this Plan.

Eligible dependents include:

- Spouse - (Working Spouse Rule applies)
- Natural, step or adopted child(ren) under age 26
- Child(ren) undergoing legal guardianship
- Child(ren) under a qualified medical child support order
- Disabled child(ren) under age 26

Waiting Period: 1st day of the month following hire date for this Employer.

Working Spouse Rule:

New for January 1, 2024

If the spouse of the Employee is employed and eligible for coverage under their own employer (regardless of cost), that spouse will NOT be eligible for coverage through this plan. The Working Spouse Rule does not require a spouse to enroll in his/her employer's plan. However, if the spouse is eligible to enroll, there will be no coverage under this plan. Exception: If the spouse of the employee is employed and eligible for coverage under their own employer (regardless of cost), that spouse may be covered as secondary under this plan if the employer plan of the spouse does NOT meet the ACA's minimum value requirements. The spouse must be enrolled in their employer's plan and that plan will pay as primary to this plan. This exception does not apply if the employer of the spouse offers multiple plan options and at least one of the options meets ACA minimum value requirements.
No person may be an employee and a dependent of this Plan.

It is the responsibility of the employee to notify the Human Resources Department if the spouse's eligibility changes anytime during the year. The employee has 30 days to notify the Human Resources Department. Failure to notify the Human Resources Department of other coverage available to a spouse may be considered insurance fraud and will result in immediate loss of coverage for the spouse. The employee will be responsible for all applicable premiums and any claims paid on the ineligible spouse. Furthermore, additional disciplinary action may be taken against the employee including possible termination of employment, subject to this employer's personnel policy.

If after reading the information in this guide you have any additional questions, please contact Dunn & Associates or Julie Nobbe.

CONTACT INFORMATION

		Phone	Website
Employer City of Greensburg Julie Nobbe		(812) 663-8582	jnobbe@greensburg.in.gov
Medical Claims Questions Eligibility Questions		(800) 880-9960 Penny Wolter	www.dunnbenefit.com pwolter@dunnbenefit.com claimsdept@dunnbenefit.com eligibility@dunnbenefit.com
Pharmacy Benefit Manager		(866) 921-4047	www.truerx.com RxBin 020958 RxPCN 0796000 RxGrp TRUE1995
Precertification		(800) 227-2298	www.clinix.com
PPO (Encore)		(888) 574-8180	Your plan utilizes the Encore Health network. This network includes providers in your area. If you have any questions concerning the status of a provider in the network, please feel free to contact Encore Health network directly (888) 446-5844 or at www.encoreconnect.com.
Telemedicine		(833) 794-3863	www.swiftmd.com
Dental Plan		(800) 524-0149	www.deltadentalin.com
Vision Plan		(800) 877-7195	www.vsp.com

Schedule of Benefits

BENEFIT SUMMARY – TRADITIONAL PLAN

If there is a conflict in terms of benefits between the benefit summary and the Summary Plan Description booklet the benefits described in the SPD will supersede in determining benefits paid. For a copy of your most recent SPD and any applicable amendments you can request from your Employer, or you can visit www.dunnbenefit.com.

See SPD for more details – this is a summary for informational purposes.

MEDICAL	DCMH Facility	In-Network	Out-of-Network
Deductible Single/Family	$0/$0	$750/$1,750	$1,500/$3,500
Coinsurance Limit - Medical Single/Family	$1,250/$1,750		$2,500/$4,000
Coinsurance Limit - Rx Single/Family	$500/$1,000		$500/$1,000
Out of Pocket Maximum Single/Family	$2,500/$4,500		$4,500/$8,500
Covered Expenses	80% no deductible	80% after deductible	60% after deductible
Preventative Care	100% no deductible	100% no deductible	100% no deductible
Preventative health care services include: ➢ Evidence-based items or services that have a rating of "A" or "B" and are currently recommended by the U.S. Preventive Services Task Force ➢ Immunizations that are currently recommended by the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention (CDCP) ➢ Evidence-informed preventive care and screenings (as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents ➢ Additional preventative care and screenings (as provided for in the comprehensive guidelines supported by the HRSA) for women Pediatric oral and vision exams will be covered under the preventative benefit in accordance to the recommendation in the PPACA.			
Office Visit (PCP/Specialist) Allergy Injection	$20 copay $5 copay (DCMH Owned Physician)	$25 copay $5 copay	60% after deductible 60% after deductible
Urgent Care	80% no deductible	80% after deductible	60% after deductible
Emergency Care Facility Physician	$150 copay then 80% no deductible 80% no deductible	$250 copay then 80% no deductible 80% after deductible	$250 copay then 80% no deductible 80% after deductible
Hospital Expenses Inpatient Outpatient	80% no deductible 80% no deductible	80% after deductible 80% after deductible	60% after deductible 60% after deductible
Xray's Outpatient	$20 copay	80% after deductible	60% after deductible
Outpatient Lab Expenses Designated Facility	100% no deductible 100% no deductible	80% after deductible 100% no deductible	60% after deductible n/a

MEDICAL	At DCMH	In-Network	Out-of-Network
Organ Transplant	*Please refer to the fully insured Organ Transplant policy.*		
Dialysis	*Payable at 200% of Medicare Fee schedule. Limit of 50 treatments per episode of care. Treatment will be considered a separate episode of care if more than 180 days have lapsed since the last treatment.*		
Mental Health Inpatient Outpatient	 80% no deductible $20 copay	 80% after deductible $25 copay	 60% after deductible 60% after deductible
Home Health Care (limit 100 visits/4hrs per visit)	80% no deductible	80% after deductible	60% after deductible
Skilled Nursing Facility (limit 30 days)	80% no deductible	80% after deductible	60% after deductible
Physiotherapy (limit 20 visits per therapy type)	80% no deductible	80% after deductible	60% after deductible
Voluntary Second Surgical Opinion	100% no deductible	100% no deductible	100% no deductible

DENTAL BENEFITS (Administered by Delta Dental)	
Deductible	No Deductible
Annual Maximum	$1,500 per person annual maximum
Diagnostic/Preventative	100% no deductible
Basic Services	80% no deductible
Major Services	50% no deductible
Orthodontic Services	50% no deductible up to $1,000 lifetime maximum (up to age 18)

VISION BENEFITS (Administered by VSP)	
Deductible	No Deductible
Annual Exam	$10 copay
Frames/Lenses	$30 copay up to $150 annual maximum
Contact Lenses	$30 copay up to $130 annual maximum

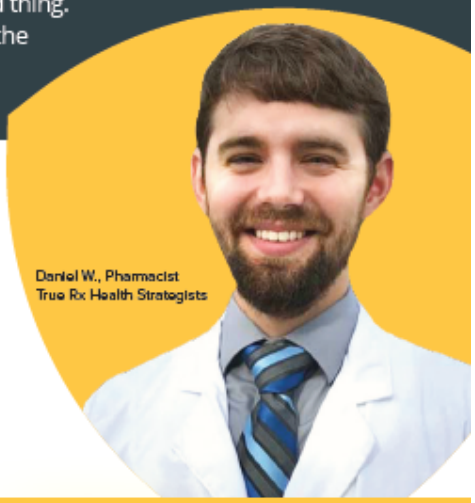
PRESCRIPTION DRUGS	
Generic – 30-day supply Preferred – 30-day supply Non-Preferred – 30-day supply Generic – 90-day supply Preferred – 90-day supply Non-Preferred – 90-day supply	$4.00 $35.00 $75.00 $10.00 $70.00 $150.00
Specialty Rx	*Specialty drugs will no longer be covered under this plan if the patient qualifies for patient assistance from the drug manufacturer or any other available assistance plan. If the patient does not qualify for assistance, coverage will be available under this plan. TrueRx will provide guidance and instruction for the patient to assist with the qualification process.*

FOR PATIENTS

trueRx
HEALTH STRATEGISTS

WELCOME TO YOUR NEW PHARMACY INSURANCE

The word "change" probably elicits some uncomfortable feelings. In this case, a change in your pharmacy insurance is actually a good thing. We're a team of pharmacists and strategists helping you get the medication you need at a price everyone can afford.



The trueDifference:

YOU'RE MORE THAN A NUMBER
At True Rx Health Strategists, you become our patient. Our motivation is your health and quality of life.

SMART MEDICATION CHOICES
made by ethical health care providers. Our formularies are designed to keep you healthy and productive.

AFFORDABLE SPECIALTY
If you take a specialty medication, your dedicated case manager will reach out to you soon.

OUR MOBILE APP
lets you compare prices at different pharmacies, set up refill reminders, and access your medication history.

IMPORTANT NEXT STEPS

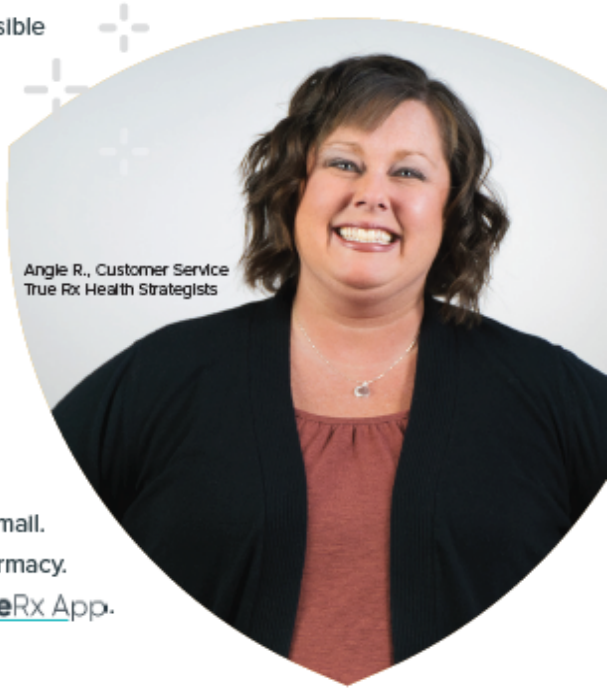
1. **LOOK** for your new insurance card in the mail.
2. **TAKE** your new card to your pharmacy.
3. **CREATE** your account at truerx.com/member-portal.
4. **DOWNLOAD** trueRx App.

How do I continue my mail order service?

If your employer offers home delivery options, you will need to contact Postal Prescription Services as soon as possible at www.ppsrx.com or 800-552-6694.

Is True Rx Health Strategists a pharmacy?

No, we're not a pharmacy. We're your pharmacy insurance provider. You will continue to receive medications at your local pharmacy while we work in the background to make sure you're getting prescriptions with ease and accuracy.



How do I get my prescriptions filled?

Soon, you will receive your new insurance card in the mail. Simply take your new insurance card to your local pharmacy. You can also access your card on your phone with **true**Rx App.

How much will my medication cost?

You can find the cost of your medication on the **true**Rx App and compare prices at different pharmacies in your area. You will also see your deductible and other specific information based on your insurance plan.

What should I do if my claim is delayed or denied?

The first thing you should do is take your new insurance card to the pharmacy to make sure they have your new insurance information. If you're still having difficulties, please give us a call. Our customer service representatives are experts in your pharmacy benefit plan.

We're here to answer any additional questions.
Reach us at hello@truerx.com or 866-921-4047.

trueRx HEALTH STRATEGISTS

trueRx HEALTH STRATEGISTS

6 WAYS TO REDUCE YOUR MEDICATION COSTS

Prescription costs rise year after year. Your team of pharmacists at True Rx Health Strategists may be able to help reduce your medication costs with these strategies:

1. ## Compare Prices Of Your Medication At Different Pharmacies

Each pharmacy may charge a different price for the same drug. Shop pharmacies on the **true**Rx App and purchase your medication for less.

2. ## Ask If A Generic Option Is Available

Why stick with brand names when you can save money with generic medications? Sometimes a higher priced brand name doesn't mean it is better. Generic medications can offer the same treatment, saving you money.

3. ## Check The Form Of Your Medication

Capsules, tablets or liquid forms of the same drug may have different prices. Try choosing the least expensive form to deliver the same treatment.

4. ## Combining Two Common Medications Into One Pill Can Be Expensive

It may seem like a convenience to take one pill instead of two, but convenience can come with a significantly higher price tag. If you think you have been prescribed a medication like this, call True Rx Health Strategists or ask your local pharmacist.

5. ## Help For High Cost Brand Medications

If you are prescribed a high cost medication, ask your doctor, local pharmacist, or call True Rx Health Strategists to see if a discount card is available.

6. ## Ask About Assistance For Specialty Medications

Do you take a specialty medication? Our specialty care team are experts in this area and understand the challenges. Your specialty case manager is dedicated to assisting you.

Have questions about your medications?

You have a team of pharmacists and patient care experts to help you navigate the ever changing world of pharmacy. If you have a question about your medication cost, please contact us.

trueRx HEALTH STRATEGISTS
866•921•4047
hello@truerx.com
truerx.com

OnTrack BY TRUE RX | Diabetes Management Program

Get personalized diabetes and health coaching

OnTrack Diabetes Management is a new program for employees and adult family members who have diabetes and are on our pharmacy benefit plan.

Email diabetes@truerx.com to enroll.

One-To-One Visits

Get care, coaching, and tips with a clinical pharmacist trained specifically in diabetes management.

Action Plan for Your Health Goals

You are more than your A1C. Create an action plan to boost overall health.

Free Testing Supplies

Actively participate and get free diabetes testing supplies.

To learn more or schedule a visit, email **diabetes@truerx.com**

OnTrack Diabetes Management is offered by clinical pharmacists with True Rx Health Strategists, our pharmacy benefits company.

trueRx HEALTH STRATEGISTS

FOR PATIENTS

trueGenomics

WELCOME TO MEDICATION MATCHMAKING.

Let's talk about Claire. She has a heart condition. Claire tried several different medications, but suffered from severe side effects and stopped taking them. She knows she needs to improve her heart health, but doesn't know the answer. Let's see how an innovative program can genetically match Claire with her ideal medication.

HOW trueGenomics WORKS:

1. ### What is trueGenomics?

Claire's pharmacy benefits plan includes trueGenomics, a pharmacogenomics program. Pharmacogenomics is the relationship between the medication she takes and how her unique genes determine her body's response to them.

2. ### Who does trueGenomics help?

1 in 5 patients could have a gene interaction to medication and would benefit from trueGenomics. Because Claire has a high-risk condition and her heart medication is sensitive to pharmacogenomics, Claire is an ideal candidate.

3. ### How does trueGenomics work?

Claire receives a test kit in the mail. She follows the simple instructions for the at-home cheek swab and mails it back to the lab using the enclosed mailing label.

trueRx
HEALTH STRATEGISTS

4 **Pharmacists' Review**

A team of pharmacists at True Rx Health Strategists examines the results and evaluates how Claire's medications can be personalized to her needs. Pharmacogenomics is relevant to medications for many common health conditions, such as mental and heart health.

5 **The Right Medication Fit**

Claire is notified through a secure website about her results. A clinician at True Rx Health Strategists reaches out to Claire and her provider to recommend a medication that will reduce side effects and increase effectiveness.

6 **Clinical Follow-up**

After talking with her doctor, Claire feels confident to try the recommended medication. Working with her doctor and the clinical team at True Rx Health Strategists, Claire receives regular monitoring to assess her health.

The trueDifference:

Thanks to **true**Genomics, Claire reduces her risk of heart attack and stroke and does not take a medication with adverse side effects. Claire saves future medical costs of potential surgeries and visits to the ER. She knows she is taking the right medication based on her genetic profile.

Are you ready for smarter pharmacy solutions with **true**Genomics?

Contact True Rx Health Strategists at hello@truerx.com.

trueRx HEALTH STRATEGISTS
866-921-4047
hello@truerx.com
truerx.com

LAB PROGRAM

Quest Diagnostics®

QuestSelect™ Plus lab benefit

Control the cost of your healthcare

QuestSelect™ Plus is a value-added health benefit that can help save you money on outpatient laboratory testing. Show your healthcare provider your QuestSelect card to obtain outpatient testing at a reduced out-of-pocket cost.

For a current listing of collection sites visit QuestSelect.com. On the website you can also:

- Print a QuestSelect card
- Read instructions on how to use your QuestSelect benefit
- Find resources you can share with your healthcare provider

To receive the benefits of the QuestSelect Plus program, you must present your QuestSelect card or healthcare ID card with the QuestSelect logo on it at the time of each service, and request your provider send your laboratory testing order to Quest Diagnostics.

The QuestSelect Plus laboratory benefit covers routine outpatient testing. It does NOT cover:

- Testing ordered during hospitalization
- Lab work needed on an emergency basis
- Testing done at another laboratory
- Time-sensitive esoteric testing such as fertility testing, bone marrow studies, and spinal fluid tests

The QuestSelect program is completely voluntary and provides you with significant savings for your covered outpatient laboratory testing. If you and/or your healthcare provider choose to send testing to any laboratory other than Quest Diagnostics, the QuestSelect benefit will not apply.

Saving with QuestSelect™ is simple

1. At your appointment, show your QuestSelect card and ask for your lab work to be sent to Quest.
2. If the office doesn't use Quest for testing, you can ask your provider to call the QuestSelect Lab Line to request a pickup. Or you can ask your provider for a written order to have your lab work collected at an approved Quest Patient Service Center (PSC) location.
3. The sample is collected at the healthcare provider's office or PSC and is sent to Quest Diagnostics for processing.
4. Testing is completed by Quest and results are sent to your provider. You can also access your results through MyQuest™ online.

For more information about your QuestSelect Plus laboratory benefit, visit QuestSelect.com or call 1.800.646.7788 today.

Frequently asked questions

Q. What is QuestSelect?
A - QuestSelect™ is a voluntary program that allows you to obtain outpatient laboratory testing* at low or no cost to you. When your doctor orders lab testing, you can reduce or eliminate co-pays and/or deductibles by showing your QuestSelect™ card and asking to use your QuestSelect™ benefit. The testing must be covered and approved by your health benefit plan and your physician or phlebotomist must indicate that you have QuestSelect™ coverage on a Quest Diagnostics requisition which accompanies your specimens to Quest Diagnostics.

Q. Is use of QuestSelect mandatory?
A - No. This is a voluntary, member-driven program. However, if you choose not to use QuestSelect™, your normal benefits will apply.

Q. Does QuestSelect replace current healthcare benefits?
A - No. It simply provides you the option to receive covered outpatient laboratory testing at low or no out-of-pocket cost to you* when you present your QuestSelect™ card and ask to use QuestSelect™.

Q. Who pays for the laboratory testing when I use QuestSelect?
A - When you use QuestSelect™, your health benefit plan pays some or all of the cost of covered outpatient lab tests - which means deep discounts of up to 100% for you.

Q. What tests are covered under QuestSelect?
A - The program covers diagnostic outpatient laboratory testing provided the tests have been ordered by your physician, are covered and approved by your health benefit plan and you have requested to use QuestSelect™. Outpatient lab work includes:

- Blood testing (e.g., cholesterol, CBC).
- Urine testing (e.g., urinalysis).
- Cytology and pathology (e.g., pap smears, biopsies).
- Cultures (e.g., throat culture)

Q. What tests are NOT covered under QuestSelect?
A - QuestSelect™ does not cover:

- Lab work ordered during hospitalization.
- Lab work needed on an emergency (STAT) basis and time-sensitive, esoteric outpatient laboratory testing such as fertility testing, bone marrow studies and spinal fluid tests.
- Non-laboratory work such as mammography, x-ray, imaging and dental work.
- Lab work performed without the use of your QuestSelect™ benefit.
- Testing that is not approved and/or covered by your current health benefit plan

Q. Is there a charge for specimen collection?
A - When your specimen is collected at your physician's office, any charges from the physician's office for this service are billed to your health benefit plan. Provider collection and handling fees may apply and are subject to health benefit plan provisions. Members will not be asked to pay for specimen collection out of pocket.

For a complete list of Frequently Asked Questions, please visit QuestSelect.com.

LAB PROGRAM

There are some other preferred lab options (not required) you can explore. These options may depend on where you live and travel time. Visit the website to determine the closest location to you. Benefits are 100% after deductible.

Alverno Labs –www.alvernolabs.com

LabCorp - https://www.labcorp.com/patients

Benefit Tip

Topic:
Low Cost Labs – City of Greensburg

Low Cost Outpatient Labs:

When possible, you can **save as much as 70-80%** by taking your lab orders to one of these draw sites. Your plan covers these locations at 100% as **Designated Lab Facilities.**

Local

DCMH Outpatient Labs – DCMH Hospital and Owned Physicians

DCMH Labs	720 N Lincoln St	812-663-9289
Medical Arts Plaza	955 N Michigan Ave Ste 4	812-663-9289

Surrounding Areas / Indy

Quest Diagnostics www.questdiagnostics.com - Any location

Nearby Quest Locations:

AccuDoc Urgent Care – **Batesville**	20 Alpine Dr	812-932-3224	Appt or Walk-in
Quest Diagnostics – Greenfield	740 W Green Meadows Dr	866-697-8378	Appt or Walk-in
Quest Diagnostics – **Greenwood**	333 E County Line Rd Ste C	866-697-8378	Appt or Walk-in

Alverno Laboratories www.alvernolabs.com - Any location Multiple Indy locations

St Francis/Franciscan Office – **Columbus**	123 2nd St	800-937-5521	Appt or Walk-in
St Francis/Franciscan Office – Greenwood	747 E. County Line Rd, Suite C	800-937-5521	Appt or Walk-in

Labcorp www.labcorp.com/labs-and-apointments - Any location

Near St Francis Hospital– Indianapolis	7855 S Emerson Ste R	317-889-5970	Appt or walk-in
Mid-America Clinical Lab – Indianapolis	8937 Southpointe Dr Ste B2	317-889-9861	Appt or Walk-in

SwiftMD is a telemedicine program that is available to you and your dependents (check your groups eligibility rule) 24/7/365. You can talk to a Dr. anytime by phone.

Getting Started is Easy!
Download the app on your phone or go to SwiftMD.com and click "Get Started"

1. You will receive an activation email to set your password and access your account;
2. Scheduling a consult with a doctor takes just a few minutes online;
3. You can upload photos if you have visible symptoms;
4. After your consultation, you can view your visit notes online, and down load them to share with your Primary Care physician.

GROUP PASSCODE = !CTYGRN17

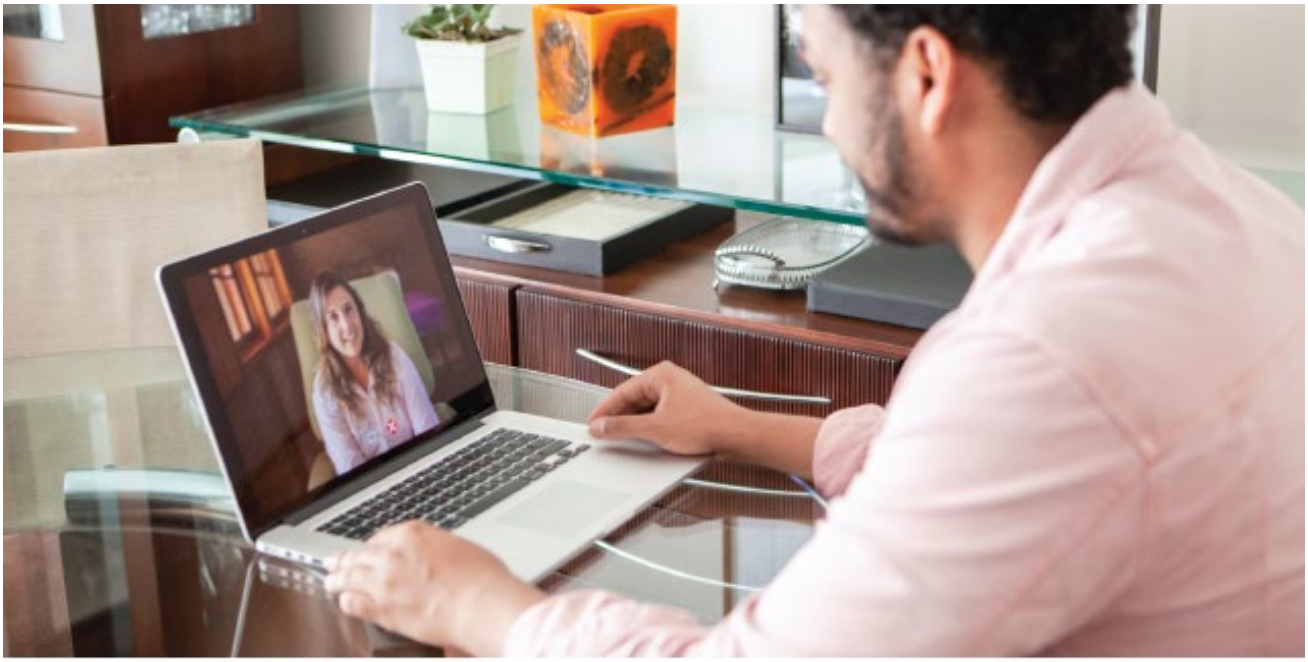
SwiftMD physicians are at the core of what they do. Their Dr's are US-trained in Emergency or Family medicine and are board certified. Experienced in diagnosing a range of illnesses and injuries. Have a minimum of ten years' experience.

Your family members can schedule consultations for other registered family members. Parents or Guardians are required to oversee telemedicine consultations for dependents under age 18. Telemedicine is not recommended for children under age 3. When a child is unable to describe their symptoms, it is important to see a Pediatrician for Family physician.

Conditions that Can be treated…

- Allergies/Rashes
- Arthritis Pain
- Back Pain/Injury
- Cold Sores
- Diarrhea
- Earache
- Conjunctivitis/Pink Eye
- Urinary Tract Infection
- Vomiting
- Fever
- Flu
- Headache
- Insect bites/stings
- Lyme Disease
- Muscle Pain/Injury
- Nasal congestion
- Any other individual concerns
- Nausea
- Respiratory congestion
- Sinusitis
- Respiratory infection
- Soft tissue Pain/Injury
- Sore Throat
- Stomachache

SwiftMD does not replace your primary care physician or specialists managing chronic and serious conditions. SwiftMD doctors do not prescribe controlled substances, psychiatric and certain other medications. For more information review the Exclusionary criteria at www.SwiftMD.com.



SwiftMD Behavioral Health Counseling

Help support your employees' total well-being!

Add SwiftMD behavioral health services to your telehealth program, providing members 24/7 access to qualified mental health support.

Services include:

- Phone or video access to master's level, state-licensed counselors in all 50 states
- Counselors trained in clinical assessments, care coordination and management, with case experience in substance abuse and domestic violence, and qualified to provide support for a broad range of work and life issues
- Referral to in-person care if needed

Adding Behavioral Health Services:

- Capitated PEPM with initial assessment and up to four visits per incident at no cost to the member
- Behavioral Health is covered under your SwiftMD savings guarantee!

For a proposal email **sales@swiftmd.com** or call **800-930-7579**

Support for a range of work and life issues

- Work or personal conflicts
- Co-dependency
- Reliance on alcohol, tobacco, or drugs
- Eating disorders
- Marital, family, and relationship concerns
- Child or elder care matters
- Stress or anxiety
- Sexual, physical, or emotional abuse
- Difficulty communicating with people
- Depression or grief at home or work

SWIFTMD
Talk to a Doctor. Anytime. Anywhere.
A REVIVEHEALTH COMPANY

SwiftMD is a telemedicine service that delivers quality, convenient healthcare via phone and videoconference 24/7!

Voluntary Benefits

Delta Dental Contributions	Monthly Premium	Cost per Pay (48)
Employee	$ 31.51	$ 7.88
Employee + 1	$ 60.94	$ 15.24
Employee + 2 or more	$ 122.22	$ 30.56

Delta Dental of Indiana
Dental Benefit Highlights for
City of Greensburg #0491

Delta Dental PPO™ (Point-of-Service) *Coverage effective* ***January 1, 2024***	Delta Dental PPO™ Dentist Plan Pays	Delta Dental Premier® Dentist Plan Pays	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Sealants - to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services - fillings and crown repair	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Relines and Repairs - to prosthetic appliances	80%	80%	80%
Major Services			
Major Restorative Services - crowns	50%	50%	50%
Prosthodontic Services - bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	through age 18 and under		

** When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges and you are responsible for that difference.*

Maximum Payment – $1,500 per Member total per Benefit Year on all services except orthodontic services. $1,000 per Member total per lifetime on orthodontic services.

Deductible – $50 Deductible per Member total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, and orthodontic services.

Benefit Waiting Period – There is a 12-month waiting period for certain services. Major Restorative Services and Prosthodontic Services will not be covered until after a Member is enrolled in the dental plan for 12 consecutive months. Orthodontic Services will not be covered until after a Member is enrolled in the dental plan for 24 consecutive months.

Note - *This document is only intended to provide a brief description of your benefits. Please refer to your Certificate and summary for a complete description of benefits, exclusions, and limitations.*

Welcome to Indiana's largest dental benefits family!

As a member of Delta Dental of Indiana, you have access to the nation's largest dental networks: Delta Dental PPO and Delta Dental Premier.

- It's easy to find a dentist! Four out of five dentists nationwide participate in our network.
- You have superior access to care and fee savings because of our agreements with participating dentists.
- Our dentists cannot balance bill you, which means more money in your pocket!
- No troublesome paperwork! Network dentists will fill out and file your claims.
- Pay only your copayments and/or deductibles when you receive care from network dentists -- there are no hidden fees.
- You can still visit nonparticipating dentists, but you may be billed the full amount at the time of service and then have to wait to be reimbursed.

Quality Dental Program

With our quick and accurate claims processing, *we pay more than 90% of claims in 10 days or less.* Delta Dental also offers world-class customer service from our BenchmarkPortal Certified Center of Excellence call center.

Online Access

Our online Member Portal lets you access your dental plan securely over the Internet. You can find a dentist, check benefits, select paperless notices, review claims and amounts used toward maximums, print ID cards, and more -- all at your own convenience.

A Healthy Smile

Keep your smile healthy with dental benefits from Delta Dental. Your smile is a good indicator of your health. Did you know that your dentist can detect up to 120 different diseases, including diabetes and heart disease? Early detection is one of the best ways to prevent further complications.

Questions?

If you have questions, please call our Customer Service team at 800-524-0149 (TTY users call 711) or look online at https://www.DeltaDentalIN.com.

VSP® Vision care for life

VSP Vision	Monthly Premium	Cost per Pay (48)
Employee	**$10.31**	**$2.58**
Employee + 1	**$15.73**	**$3.94**
Employee + 2 or more	**$28.21**	**$7.06**

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every calendar year
PRESCRIPTION GLASSES		$30	See frame and lenses
FRAME	• $170 featured frame brands allowance • $150 frame allowance • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
PRIMARY EYECARE℠	• Retinal screening for members with diabetes • Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration. • Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members. • Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 $20 per exam	As needed
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM CITY OF GREENSBURG AND VSP.

VSP Vision care for life

Enroll in VSP® Vision Care to get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

PREMIER PROGRAM

Like shopping online? Go to **eyeconic.com** and use your vision benefits to shop over 50 brands of contacts, eyeglasses, and sunglasses.

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

GET YOUR PERFECT PAIR

EXTRA $20 TO SPEND ON FEATURED FRAME BRANDS*

bebe CALVIN KLEIN COLE HAAN FLEXON LACOSTE NINE WEST

SEE MORE BRANDS AT VSP.COM/OFFERS.

\+

UP TO **40%** SAVINGS ON LENS ENHANCEMENTS

EXCLUSIVE MEMBER EXTRAS

Enroll today.

Contact us: **800.877.7195** or **vsp.com**

IMMEDIATE CARE CLINIC

because minor emergencies deserve major attention

Immediate Care Clinic
955 N. Michigan Avenue, Suite 4
Greensburg, Indiana 47240
(812) 662-6450
www.dcmh.net

Decatur County Memorial Hospital
IMMEDIATE CARE CLINIC

(812) 662-6450
955 N. Michigan Avenue, Suite 4
Greensburg, Indiana

WHEN YOU NEED US

The Immediate Care Clinic is not emergency care, however it is quality care that is provided conveniently and timely for those minor illnesses and injuries. We cover a wide range of services including:

MEDICAL MINOR INJURIES:

- Abrasions
- Minor burns
- Minor cut closure
- Splinters
- Sprains
- Staple/Suture Removal
- Strains

MEDICAL MINOR ILLNESSES:

- Allergies
- Bladder Infections
- Breathing Treatments
- Bronchitis
- Common Cold
- Coughs
- Diarrhea, Nausea and Vomiting
- Ear Infections
- Swimmers' Ear
- Fever
- Flu
- Laryngitis
- Mononucleosis
- Pink Eye and Styes
- Sinus Infections
- Sore Throat
- Strep Throat
- Upper Respiratory Infections

MEDICAL SKIN CONDITIONS

- Eczema
- Head lice/scabies
- Hives
- Impetigo
- Insect bites & stings
- Poison Ivy/ Poison Oak
- Rashes
- Ringword
- Shingles
- Sunburn

We want to make it as simple as possible for you. At the Immediate Care Clinic we accept walk-in patients during our normal business hours. We are closed on major holidays. Please call us if you have any questions.

MEDICAL SERVICES:

- Blood pressure checks
- Camp physicals
- School/College Physicals
- Sport Physicals

IMMEDIATE CARE CLINIC HOURS

Immediate Care

Monday-Friday	8:00 a.m.–6:00 p.m.
Saturday-Sunday	9:00 a.m. –12:00 p.m.

Patients must be signed in 15 minutes prior to close

Occupational Health

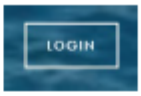
Monday-Friday	8:00 a.m. –4:30 p.m.

LABORATORY

Monday-Friday	8:00 a.m.–6:00 p.m.

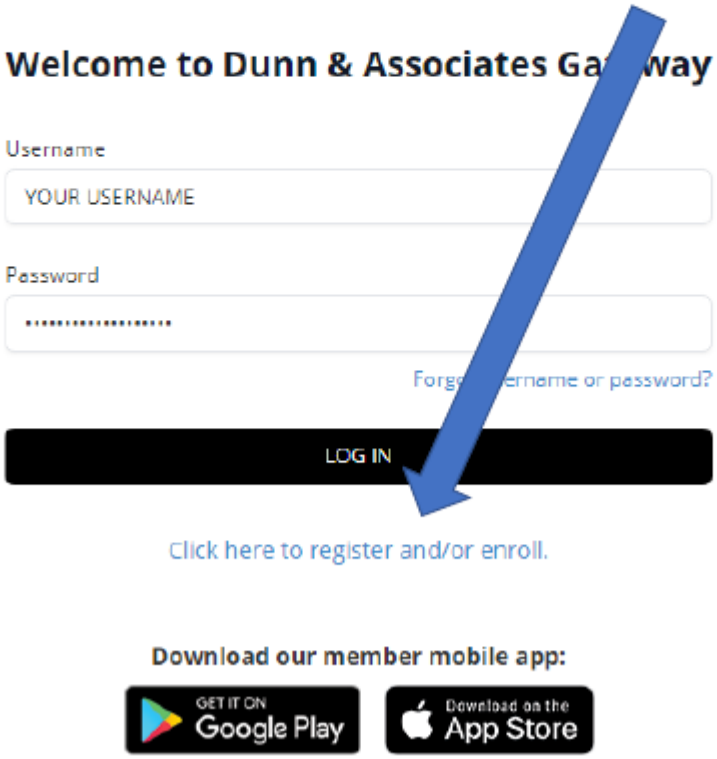
ALL USERS MUST CREATE A NEW LOGIN ACCOUNT

1. Go to www.dunnbenefit.com
2. Click on Login button in upper right hand corner of screen.

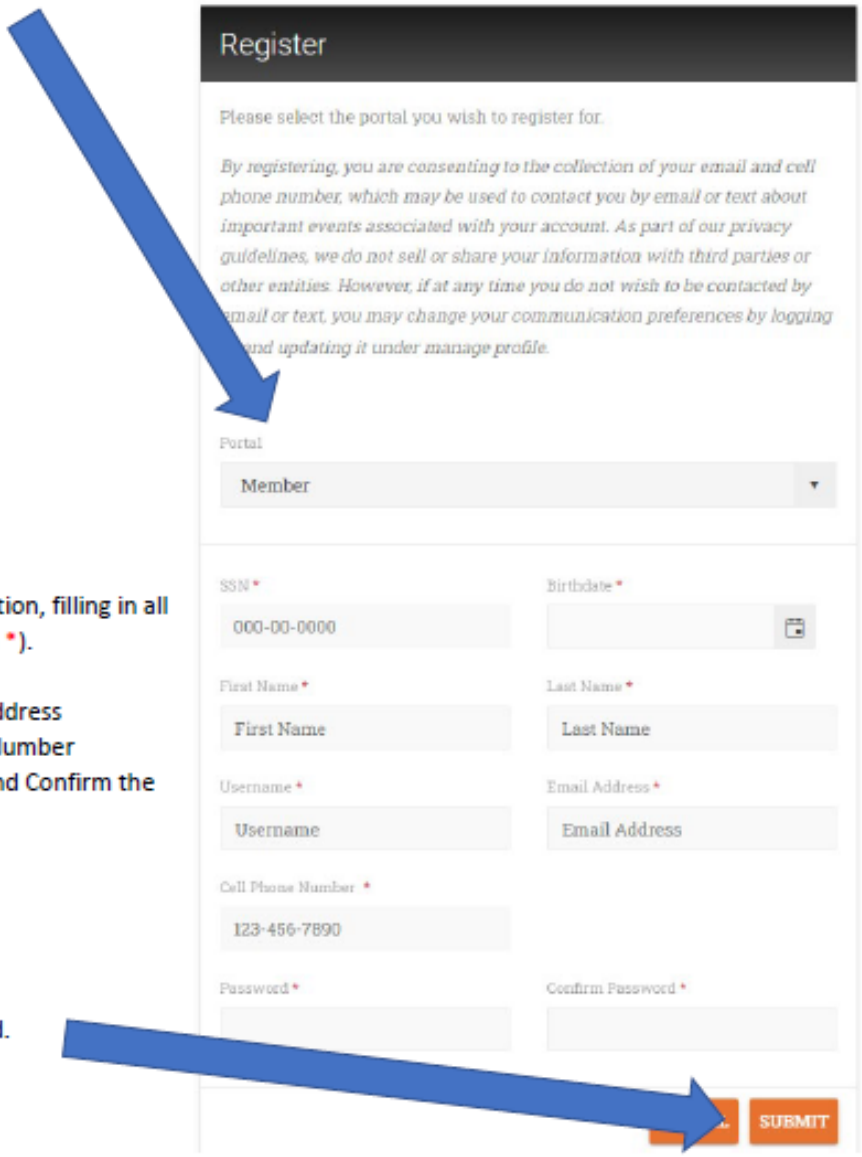


Note: If you see this button, click on it and you will see the Login button.

3. You will be directed to our NEW PORTAL! Click on the "Click here to register and/or enroll" link.



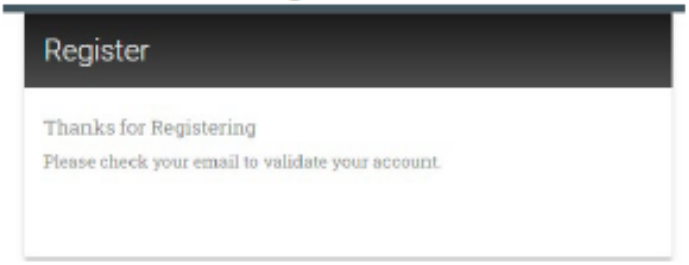
4. Select "Member" from the Portal Drop down box.



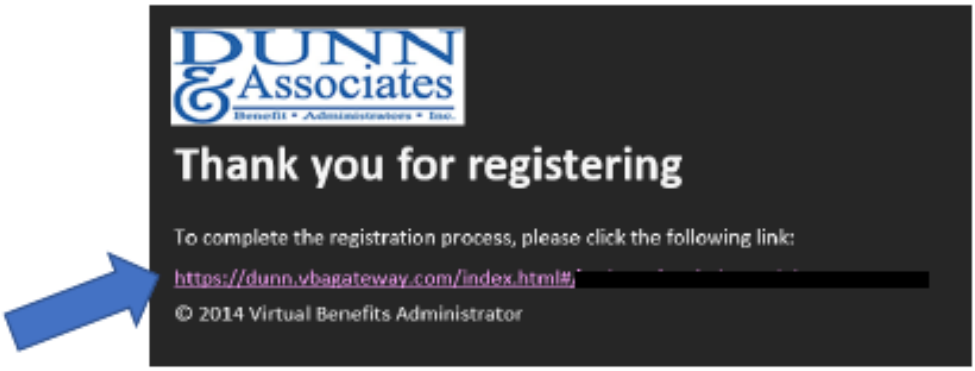
5. Enter your personal information, filling in all required fields (marked with *).
6. Create a unique Username
7. Enter your Personal Email Address
8. Enter your Personal Phone Number
9. Create a unique Password and Confirm the password entered.

10. Click "Submit" when finished.

11. You will see the following screen when finished.

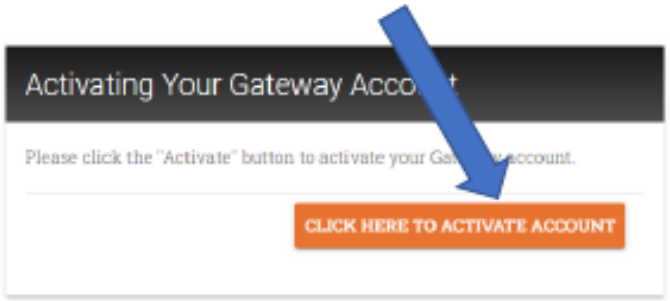


12. **GO TO YOUR EMAIL YOU ENTERED DURING REGISTRATION**, you should see an email similar to the following:

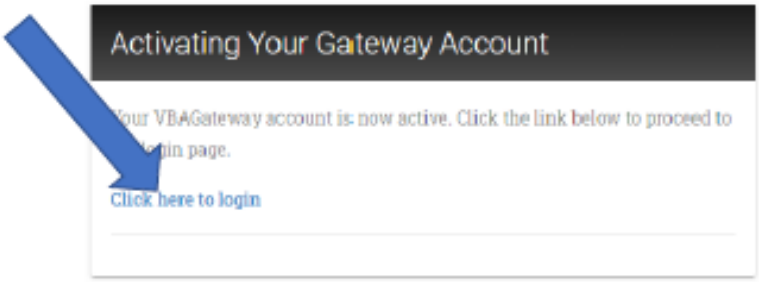


13. Click on the link in your email to complete the registration process.

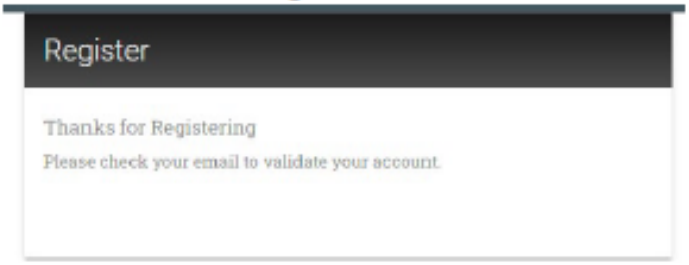
14. Click on the button to activate your account.



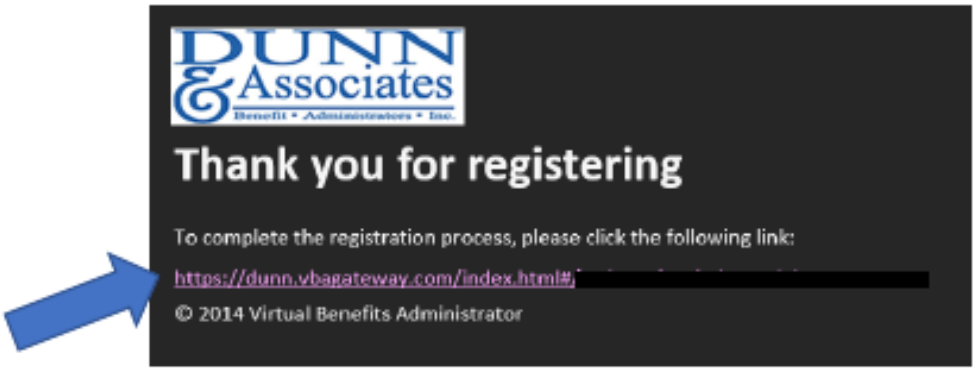
15. Click on the button to go to login.



11. You will see the following screen when finished.

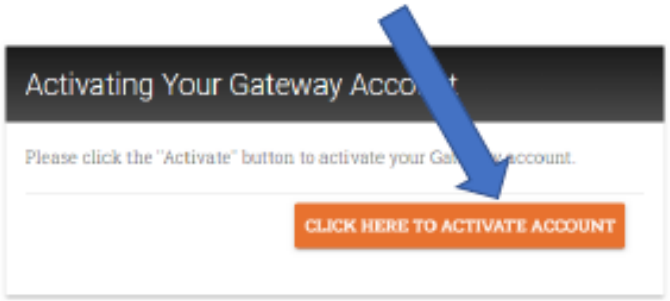


12. **GO TO YOUR EMAIL YOU ENTERED DURING REGISTRATION**, you should see an email similar to the following:

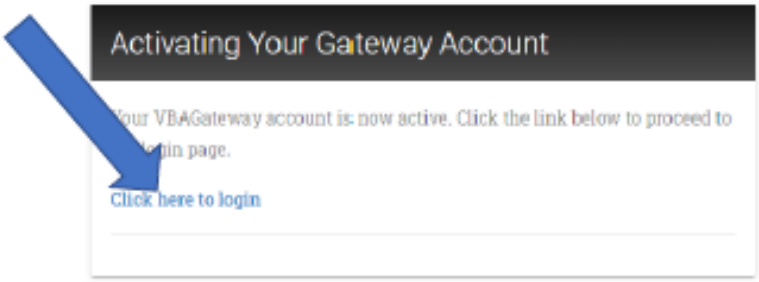


13. Click on the link in your email to complete the registration process.

14. Click on the button to activate your account.



15. Click on the button to go to login.



PREVENTATIVE CARE

What is preventative care?
Preventive care focuses on maintaining your health and establishing your health status. This may include immunizations, vaccines, physical evaluations, lab work, x-rays and medically appropriate health screenings. During your preventive visit, your doctor will determine what tests or screenings are appropriate for you based on many factors such as your age, gender, overall health status, personal health history and your current symptoms or chronic health concerns.

Recommended Screenings
Visit https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations; to see a list of recommended screenings, by age, or gender, etc…

Some examples are:

- **Breast Cancer Screenings**: Women age 40-74 years of age; USPSTF recommends biennial (every other year) screening mammography for women.
- **Colorectal Screenings**: Adults age 45-49 and 50-75 colonoscopy screening every 10 years.
- **Pre-Diabetes Screening**: Adults age 35-70 who are overweight or obese; fasting glucose lab test; every 3 years.

Preventive care can help you avoid potentially serious health conditions and/or obtain early diagnosis and treatment.

ANNUAL COMPLIANCE NOTICES

- ✓ Patient Protection and Affordable Care Act
- ✓ Prescription Drug Coverage and Medicare
- ✓ CHIP
- ✓ Paperwork Reduction Act
- ✓ Continuation of Coverage (COBRA)
- ✓ Special Enrollment Rights
- ✓ Women's Health and Cancer Rights Act
- ✓ Newborns and Mothers Health Protection Act
- ✓ Grandfathered Status under Healthcare Reform Act
- ✓ Providers Choice
- ✓ USERRA Health Insurance Protection
- ✓ Protections From Disclosure of Medical Information
- ✓ Wellness Plan – (if applicable)
- ✓ HHS Non-Discrimination Notice
- ✓ Exchange (Marketplace) Notice
- ✓ Privacy Notice

PATIENT PROTECTION AND AFFORDABLE CARE ACT

The *Patient Protection and Affordable Care Act* (PPACA) include health insurance market reforms that will bring immediate benefits to millions of Americans, including those who currently have coverage.

Enrollment Opportunity: Lifetime Limit No Longer Applies
The Lifetime Limit on the dollar value of benefits under the plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan.

Enrollment Opportunity: Extension of Dependent Coverage to Age 26 Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent children ended before attainment of age 26 regardless of whether they are eligible for other health coverage (employer-sponsored or otherwise); are eligible to enroll in the plan. Individuals may request enrollment for such children during the enrollment period. For more information, please contact your Human Resource Department. A plan that covers an Adult Child as an Employee or a Spouse will be primary to a plan that covers the Adult Child as a dependent child.

Patient Protection Disclosure:
This plan does not require the designation of a primary care provider. You have the right to seek care from any primary care provider of your choice. Designation of a primary care physician is not required for children. You do not need prior authorization from this plan or Dunn and Associates Benefit Administrators, Inc. or from any other person (including a primary care physician) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a preapproved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in primary care, pediatrics, obstetrics, or gynecology, contact Dunn and Associates Benefit Administrators at 812-827-2429 or 800-880-9960 or visit www.dunnbenefit.com.

Grandfathered Plan Status:
This group health plan believes this Plan is a "Non-Grandfathered Plan" under the PPACA. Being a non-grandfathered plan means that this Plan does include certain consumer protections under the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a non-grandfathered health plan and what might cause a plan to change from a grandfathered health plan status can be directed to the plan supervisor, Dunn and Associates Benefit Administrators at 812-827-2429 or 800-880-9960.

Prohibition of Rescissions:
PPACA prohibits a group health plan from rescinding health coverage except in the case of fraud or intentional misrepresentation of a material fact.

Prohibition on Preexisting Condition Exclusions:
PPACA prohibits a group health plan from denying coverage based on an applicant's preexisting condition.

Preventative Care:
Preventative health care services will be payable at 100% no deductible, according to Schedule A and B of Health Care Reform preventative care services. Visit www.healthcare.gov for these schedules or call Dunn & Associates.

Emergency Services:
Non-grandfathered plans must pay for emergency services at the same rate for in-network and out-of-network providers claims that are considered to be emergencies. Non-emergency care received at a hospital emergency room will not be subject to this provision.

Clinical Trials:
This plan will comply with the clinical trials process. Non-grandfathered plans must cover routine expenses for clinical trials for cancer and other life-threatening diseases and cannot discriminate against individuals for participating in the trial.

Revised Appeals Process:
This plan will comply with the updated internal appeals process and will provide participants with information about the process. This plan will also adopt an external appeals process that, at a minimum, meets the Uniform External Review Model Reform promulgated by the National Association of Insurance Commissioners. The new procedures will include claims benefit determination (whether or not adverse) involving urgent care as soon as possible, but not later than 24 hours after the plan or insurer receives the claim.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Important Notice About Your Prescription Drug Coverage and Medicare – Traditional Plan
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2007 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. Your employer has determined that the prescription drug coverage they offer is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage. Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your employer's prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan. You should also know that if you drop or lose the coverage with your employer and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage…
Contact our office for further information. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if the coverage through your employer changes. You also may request a copy. 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 prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	November 2023
Name of Entity/Sender:	City of Greensburg
Contact--Position/Office:	Julie Nobbe
Address:	314 N Washington St. Greensburg, IN 47240
Phone Number:	812-663-8582

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDRENS 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 July 31, 2016. Contact your State for more information on eligibility** – To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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.

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.hip.in.gov
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13), 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 the OMB under the PRA and displays a 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 US 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.

CONTINUATION OF COVERAGE UNDER COBRA

Employers who employ 20 or more employees are subject to the continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation of coverage can become available to you and other members of your family when group health coverage would otherwise end because of certain qualifying events such as a termination of employment for reasons other then gross misconduct, reduction in hours, divorce, legal separation, death or a child ceasing to meet the definition of a dependent under the group health plan. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse, and your dependent children could become qualified beneficiaries if group health plan coverage is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out of pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. For information about your rights and obligations under COBRA, you should review the Plan's Summary Plan Description or contact the plan administrator.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents other coverage). However, you must request enrollment 30 days after you or your dependents other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent, because of marriage, birth, adoption or placement for adoption you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or CHIP, or when you and your dependents gain eligibility for state premium assistance. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage of the determination of eligibility for a premium assistance subsidy. To request special enrollment or obtain more information, contact the plan administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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; protheses; and treatment of physical complications of the mastectomy, including lymphedema. Benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. If you would like more information on WHCRA benefits, contact the plan administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable). In any case, plans and issuers may not, under Federal law require that a provider obtain prior authorization from the plan or the insurance issuer for prescribing a length of stay in excess of 48 hours (or 96 hours if applicable).

GRANDFATHERED STATUS UNDER HEALTHCARE REFORM

This group health plan believes this Plan is a "Non-Grandfathered Plan" under the PPACA. Being a non-grandfathered plan means that this Plan does include certain consumer protections under the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a non-grandfathered health plan and what might cause a plan to change from a grandfathered health plan status can be directed to the plan supervisor, Dunn and Associates Benefit Administrators at (800) 880-9960. Questions regarding which protections apply and which protections do not apply to a non-grandfathered health plan and what might cause a plan to change status can be directed to the plan administrator. US Department of Labor (866) 444-3272 or www.dol.gov/healthreform. This website has a table summarizing which protections do and do not apply.

GRANDFATHERED STATUS UNDER HEALTHCARE REFORM

You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers contact the plan administrator; or visit your PPO networks website. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization in or to obtain access to obstetrical or gynecological care from a health care professional in network who specializes in obstetrics/gynecology. The health care professional may be required to comply with certain procedures including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating providers who specialize in obstetrics/gynecology contact the plan administrator or visit your PPO networks website.

USERRA HEALTH INSURANCE PROTECTION

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. If you leave your job to perform military services, you have the right to elect to continue your existing coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your service you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions except for service connected illnesses or injuries. For more information about your rights to continue your coverage, contact the plan administrator.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION (if applicable)

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the plan may use aggregate information it collects to design a program based on identified health risks in the workplace, it will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to request from you for a reasonable accommodation need to participate in any wellness program (if applicable) or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with any wellness program will not be provided to your employer and may never be used to make decisions regarding your employment. Your health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law to carry out specific activities related to any wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in any wellness program or receiving any incentives. Anyone who receives your information for the purpose of providing you services as part of any wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable information is/are in order to provide you with services under any wellness program. In addition, all information obtained from any wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of any wellness program will be used in making an employment decision. Specify any other or additional confidentiality protections if applicable. Appropriate precautions will be taken to avoid any data breach and in the event a data breach occurs involving information you provide in connection with any wellness program we will notify you immediately. You may not be discriminated against in

employment because if the medical information you provide as participating in any wellness program nor may you be subjected to retaliation if you choose not to participate. If you have any questions regarding this notice or about protections against discrimination/retaliation, please contact the plan administrator.

WELLNESS PLAN ALTERNATIVE STANDARD (if applicable)

Your health plan is committed to helping you achieve your best health. Rewards for participating in any wellness program may be available to employees. If you think you might be unable to meet a standard for a reward under any wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your employer and they will work with you to find an alternative that is right for you, for the same reward considering your health issue(s).

HHS NON-DISCRIMINATION NOTICE

The U.S. Department of Health and Human Services (HHS) complies with applicable Federal civil rights laws and does not discriminate on the base of race, color, national origin, age, disability, or sex. HHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. HHS provides free aids and services to people with disabilities to communicate effectively with us such as; Qualified sign language interpreters and Written information in other formats (large print, audio, accessible electronic formats, other formats), Provides free language services to people whose primary language is not English such as Qualified interpreters and Information written in other languages. If you need these services, contact HHS at, 1 (877) 696-6775. If you believe HHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights compliant portal, by mail or phone. Complaint forms are also available at *http://www.hhs.gov/ocr/office/file/index.html*

US Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1 (800) 368-1019 or 1 (800) 537-7697 (TDD)

PRIVACY NOTICE

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we *never* share your information unless you give us written permission:
- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

EXCHANGE MARKETPLACE NOTICE

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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 meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Julie Nobbe

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] An employer-sponsored 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.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
City of Greensburg		35-6001049
5. Employer address		6. Employer phone number
314 w Washington St.		812-663-8582
7. City	8. State	9. ZIP code
Greensburg	Indiana	47240
10. Who can we contact about employee health coverage at this job?		
Julie Nobbe		
11. Phone number (if different from above)	12. Email address	
	jnobbe@greensburg.in.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☑ Some employees. Eligible employees are:

Please refer to the eligibility section of the Summary Plan Description booklet. If you do not have an SPD, one can be found at www.dunnbenefit.com or you may request one from your Employer.

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

Please refer to the eligibility section of the Summary Plan Description booklet. If you do not have an SPD, one can be found at www.dunnbenefit.com or you may request one from your Employer.

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.