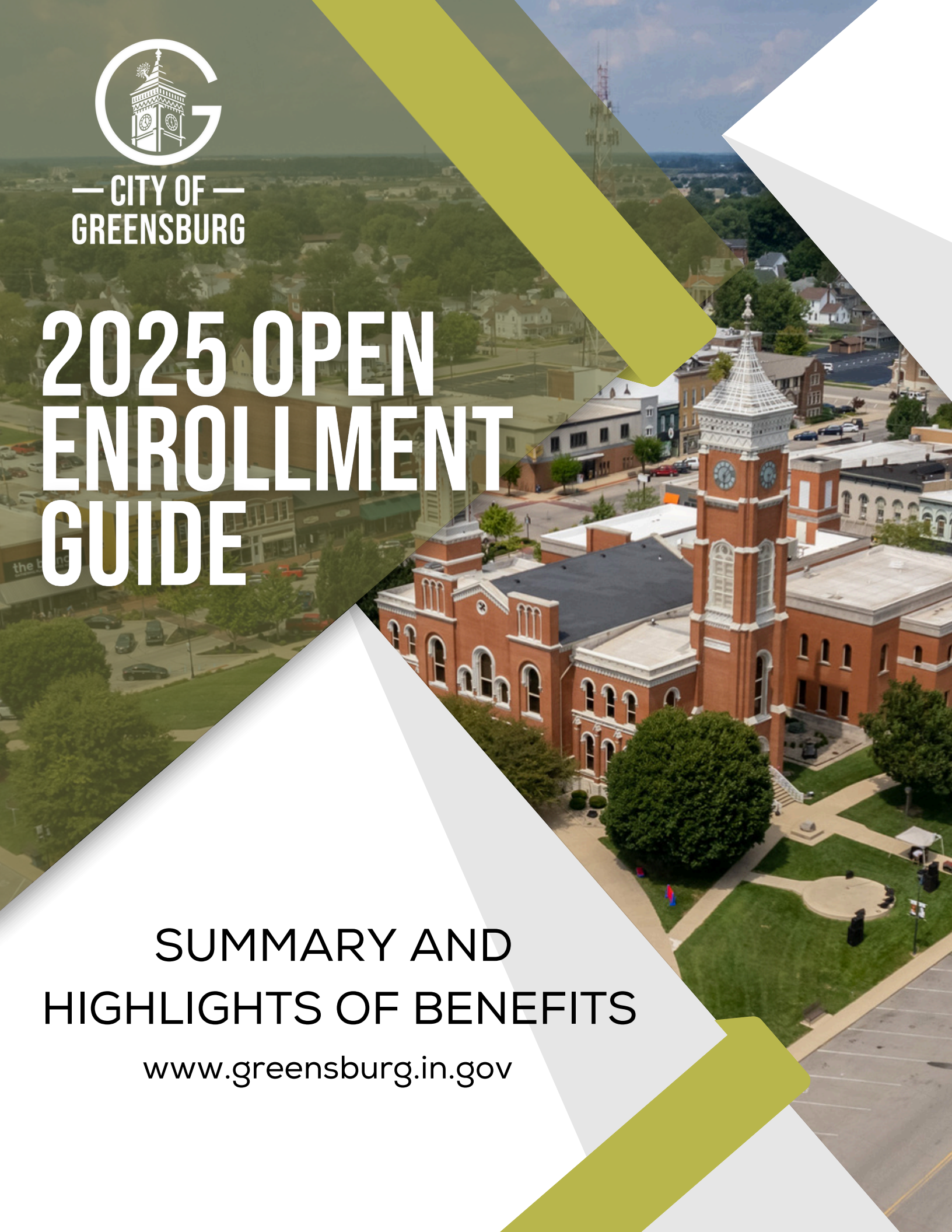
CITY OF GREENSBURG

2025 OPEN ENROLLMENT GUIDE



SUMMARY AND HIGHLIGHTS OF BENEFITS

www.greensburg.in.gov

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The following will be offered to the City of Greensburg employees and their eligible dependents as of January 1, 2025. 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.

Benefits for You & Your Family

You play an imperative part in the plans victory. That is 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 the 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 update your benefit enrollments. The benefits you choose during this time will be effective **January 1, 2025**.

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

If you and your spouse are both employees of the company, dependent children can only be covered under either your coverage or your spouse's coverage, but not under both.

Working Spouse Rule

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 under this plan. See SPD for more details. The working spouse rule applies to medical benefits only.

What is Open Enrollment?

Open Enrollment is a once-a-year opportunity to update your current benefits and to review which dependents you will be covering during the new year.

Open Enrollment will be November 12th through November 22nd, 2024. All changes you request will take effect January 1, 2025.

Making Election Changes During the Year?

In most cases, your benefit elections remain in effect until the next annual open enrollment period. You will not be able to make any plan changes unless you experience a life status change.

Life Status Change Events

Events described in IRS regulations allow you to make a change to your benefit coverage if you experience any of the following:

- Marriage or divorce
- Death
- Birth or adoption of a dependent
- Change in employment status
- Dependent satisfying or ceasing to satisfy the plan's eligibility requirements
- Loss of or significant change to your current coverage
- Judgment, decree or court order
- Enrollment / ceasing to be enrolled in Medicare or Medicaid
- Ceasing to be enrolled in Children's Health Insurance Program (CHIP)

YOU HAVE 30 DAYS FROM THE DATE OF THE EVENT TO REPORT AND UPDATE YOUR BENEFITS WITH THE HUMAN RESOURCES DEPARTMENT.

Not making any changes?

If you are not making any changes, there is nothing you need to do.

Enrolling for the first time or making changes?

You are required to review the open enrollment presentation and complete the enrollment form. Make sure to see Julie Nobbe with any questions.

Waiting Period

1st of the month following hire date for this employer.

For questions regarding your benefits or enrollment options, please contact Dunn & Associates 812-378-9960 or Julie Nobbe at 812-663-8582

Enrollment Deadline – 11/22/2024!

Contact Information

Have Questions? Need Help?

	EMPLOYER	PHONE NUMBER	NAME	WEBSITE
Group Health Plan		812-663-8582	Julie Nobbe	jnobbe@greensburg.in.gov

BENEFITS PLAN	CARRIER	PHONE NUMBER	NAME	WEBSITE
Medical - Claims		812-378-9960 800-880-9960	Penny Wolter, Claims Analyst pwolter@dunnbenefit.com Tammy Shaw, Claims Mgr. tshaw@dunnbenefit.com	www.dunnbenefit.com
Eligibility		812-378-9960 800-880-9960	Eligibility@dunnbenefit.com	www.dunnbenefit.com
Pharmacy		866-921-4047		www.truerx.com
Precertification		800-227-2298		www.clinix.com
PPO		888-574-8180		www.encoreconnect.com
Telemedicine		833-794-3863		www.revive.health www.swiftmd.com
Dental		800-524-0149		www.deltadentalin.com
Vision		800-877-7195		www.vsp.com
Life and AD&D		855-553-5318		www.oneamerica.com
Voluntary Life		855-553-5318		www.oneamerica.com

Medical Insurance

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.

Medical Benefits	Traditional Plan		
	At DCMH	In-Network	Out-of-Network
Deductible (Individual/Family)	$0	$750/$1,750	$1,500/$3,500
Coinsurance (Medical)	$1,250/$1,750		$2,500/$4,000
Coinsurance (Rx)	$500/$1,000		
Out of Pocket Maximum	$2,500/$4,500		$4,500/$8,500
Covered Expenses	80% no deductible	80% after deductible	60% after deductible
Physician Office Visit (PCP/Specialist) Allergy Injections	$20 copay $5 copay *(DCMH Owned Physician)*	$25 copay $5 copay	60% after deductible
Preventive Care	100% no deductible		
Lab Tests	100% no deductible	80% after deductible	60% after deductible
Lab Test – At Designated Facility	100% no deductible (Alverno, Quest, LabCorp)		
Complex Radiology / X-ray	$20 copay	80% after deductible	60% after deductible
Urgent Care Facility	80% no deductible	80% after deductible	60% after deductible
Emergency Room Facility Charges	$150 copay 80% no deductible	$250 copay 80% no deductible	$250 copay 80% no deductible
Emergency Room Physician	80% no deductible	80% after deductible	80% after deductible
Inpatient Facility Charges	80% no deductible	80% after deductible	60% after deductible
Outpatient Facility	80% no deductible	80% after deductible	60% after deductible
Mental Health Office Visit Outpatient/ Inpatient	$20 copay 80% no deductible	$25 copay 80% after deductible	60% after deductible 60% after deductible
Home Health Care (limit 100 visits /4 hrs. 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 visit per therapy type)	80% no deductible	80% after deductible	60% after deductible
Organ Transplant	Refer to fully insured Organ Transplant		
Dialysis	Payable at 200% of Medicare Fee schedule. Limit 50 treatments per episode of care. Treatment will be considered a separate episode of care if more than 180 days have lapsed since last treatment.		
Voluntary Second Surgical Opinion	100% no deductible		

Retail Drugs (30-day supply)	
Generic (Tier 1)	$4
Preferred (Tier 2)	$35
Non-Preferred (Tier 3)	$75
Specialty (Tier 4)	No coverage
Mail Order Drugs (90-day supply)	
Generic (Tier 1)	$10
Preferred (Tier 2)	$70
Non-Preferred (Tier 3)	$150

Employee Contributions (Weekly – 48/Pays)	
Employee	$8.33
Employee & Child(ren)	$16.66
Employee & Spouse	$20.83
Employee & Family	$25.00

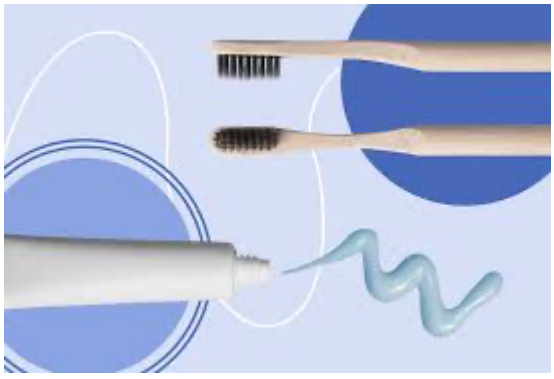
Dental Insurance

The dental plan is administered by Delta Dental and has a preferred provider organization available to help save you money. You have the freedom to select any dentist; but you pay less out of pocket when you choose an in-network provider. You may locate a dentist online at www.deltadentalin.com. The details of your plan are below.

Benefit Coverage	Dental In-Network Benefits
Deductible	$50 per person $150 family maximum
Benefit Maximum	$1,500 maximum per person
Preventive	100% Insurance pays 100% for oral exams, x-rays, and cleanings Annual Limits Apply
Basic	80% after deductible Services include fillings, extractions, periodontics, root canals and general anesthesia
Major	50% after deductible Services include crowns, dentures, fixed and removable prosthetics
Orthodontic Services	50% – Dependent Children up to age 18
Orthodontia Lifetime Maximum	$1,000 per child - Ortho applies to Child Only to age 18

Refer to the benefit summary or certificate of coverage for more information.

Employee Contributions (Weekly/48 pays)	
Employee	$8.31
Employee + 1	$16.08
Employee + 2 or more	$32.24



Vision Insurance

Sight, it's a beautiful thing and not to be taken for granted. Whether you want to be incognito and wear contact lenses or stand out in the crowd with the latest stylish frames, this vision plan has you covered. Go anywhere in the network for an exam, but we suggest you use a major retail chain when getting your frames and lenses.

The vision plan is administered by VSP who uses the VSP Network which offers a Preferred Provider Network for you to choose a vision care provider. To access a listing of providers (private practice and retail centers) logon to www.VSP.com. The benefits are below. Look them over. If they seem fuzzy, it might be time to sign up and utilize them!

Benefit Coverage	Vision Service Plan Vision	
Vision Exam	$10 copay	Every calendar year
Eyeglass Lenses	Included in frames	Every calendar year
Frames	$30 copay up to $150 allowance $170 on Featured Fram Brands	Every calendar year
Benefit after Copay		
Contact Lenses (Elective)	100% covered up to $130 allowance	Every calendar year – instead of glasses
Laser Correction Surgery Discount	Discount available	N/A

Refer to the benefit summary or certificate of coverage for more information.

Employee Contributions (Weekly/48 pays)	
Employee	$2.58
Employee + 1	$3.94
Employee + 2 or more	$7.06

PPO Network

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 at (888) 446-5844 or at www.encoreconnect.com.

Encore/Encore Combined

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:

- **Routine Annual Physical** – Children and Adults
- **Immunizations** – Routine Child Immunization, Flu, Covid-19 and age appropriate Shingles vaccine.
- **Breast Cancer Screenings**: Women age 40-74 years of age; USPSTF recommends biennial (every other year) screening mammography for women.
- **Colorectal Screenings**: Adults age 45-75 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.

Note: Your physician may charge for a regular office visit if prescribing medications or treating a medical condition that is outside the scope of the Routine Physical/Preventive visit.

Lab Program - Designated Labs

Decatur County Memorial Hospital – 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	812-663-9289Low-cost Outpatient Labs.

There are 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.

Alverno Labs –www.alvernolabs.com
St. Francis/Columbus 123 2nd St. 800-937-5521
St. Francis/Greenwood 747 E Co Line Rd 800-937-5521
Appointment or Walk-in

LabCorp - https://www.labcorp.com/patients
Near St. Francis Hospital/Indy 7855 S Emerson 317-889-5970
MidAmerica 8937 Southpointe Dr. Ste. B2 317-889-5970
Appointment or Walk-in

Quest Diagnostics (any location)
Nearby Locations:

AccuDoc Urgent Care/Batesville	20 Alpine Dr.	812-932-3224	Appointment or Walk-in
Quest Diagnostics/Greenfield	740 W Green Meadow Dr.	866-697-8378	Appointment or Walk-in
Quest Diagnostics/Greenwood	333 E Co Line Rd Ste C	866-697-8378	Appointment or Walk-in

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.

Telemedicine

REVIVE HEALTH

City of Greensburg
Group Passcode:
!CTYGRN17

Welcome To ReviveHealth!

Eligible employees and dependents can talk to a doctor 24/7 by phone or video-chat at no cost or co-pays!

- 24/7 nationwide access to Board-Certified physicians
- Consults available anytime, anywhere
- Prescriptions sent to your preferred local pharmacy
- Avoid overcrowded waiting rooms and long wait times
- NO copays, deductibles, or surprise statements

Getting Started:

1. Head to the **login page** at www.swiftmd.com and select 'Get Started'
2. Complete the required fields, inclusive of your group code: **!CTYGRN17**

You will also receive a welcome email with instructions to complete your activation.

Access care via our mobile app!

Download on the App Store

GET IT ON Google Play

Conditions We Treat

Allergies and Rashes, Arthritis Pain, Back Pain or Injury, Cold Sores, Diarrhea, Earache, Conjunctivitis or Pink Eye, Fever and Flu, Headache, Insect Bites and Stings, Lymes Disease, Sinusitis, Sore Throat, Stomach Ache and Nausea, Upper Respiratory Infections, Urinary Tract Infections, Vomiting, Your Individual Concerns

Revive health does not replace your PCP managing chronic conditions. Revive health doctors don't prescribe controlled or psychiatric medications, and certain other medications subject to abuse.

revive

MENTAL HEALTH THERAPY

City of Greensburg has added Mental Health Therapy to your benefit offering. You receive 24/7 access to exceptional mental health support.

NO claims or copays | **ALL** 50 states | Clinical Care Coordination | **EXCLUSIVE** therapists

CONVENIENT SCHEDULING

Easy access to a licensed, Master's level counselor within 1-3 days.

SAME THERAPIST EACH VISIT

See the same therapist each visit so that they can best understand your personal needs. Our counselors are trained in clinical assessments and care coordination.

Should you need in person care, our team is able to provide referrals when needed.

WHY THERAPY?

- Work or personal conflicts
- Co-dependency
- Alcohol, drugs, and/or tobacco reliance
- Eating disorders
- Stress and anxiety
- Relationship concerns
- Child or elder care matters
- Physical, sexual, or emotional abuse

To schedule a counseling session, please call toll-free at (866) 270-0762.

info@revive.health | www.revive.health | 1-888-220-6650 | 5000 Sawgrass Village Circle Suite 4, Ponte Vedra FL 32082

Immediate Care Clinic

IMMEDIATE CARE CLINIC

because minor emergencies deserve major attention

DNV·GL

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.

Life and Accidental Death & Dismemberment Insurance

City of Greensburg provides a Basic Life and AD&D benefit to eligible employees through OneAmerica. The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

Life & AD&D	
Life (Employee) Class 1 & 2	$25,000
AD&D	In the event of accidental dismemberment, a benefit is provided up to a scheduled amount corresponding to the loss. Please see your booklet for further details.

Refer to the benefit summary or certificate of coverage for more information

Voluntary Life Offerings

Preparing for death is our responsibility. One way is through providing financially for loved ones. Life insurance offers that gift. Voluntary life insurance for employees and their families is available at discounted group rates. This life insurance plan will cover you or a covered family member in the event of a death while covered by the plan.

Your designated beneficiary is the person/s to whom you have assigned your life benefits. It is important to provide clear beneficiary selection(s) to the insurance carrier. Please be sure to complete the beneficiary section of your enrollment form to avoid any potential problems for your beneficiaries. You, the employee, are automatically listed as the beneficiary on any policy for your spouse or child/ren.

Voluntary Life	Description
Voluntary Life (Employee)	Units of Increments of $10,000 to a maximum of $500,000
Voluntary Life (Spouse)	Units of Increments of $5,000 but not more a maximum of $25,000 Spouse must be under age 70 for benefits. Cannot exceed 100% of the amount selected by Employee.
Voluntary Life (Child/ren)	Units of Increments of $2,500 to a maximum of $10,000 The maximum benefit for children under 6 months of age is $1,000
Guarantee Issue Amounts	Employee -$150,000 Spouse - $25,000 Child - $10,000 Voluntary Life guarantee issue amounts only apply to new hire employees electing coverage within their original eligibility period. All others will be subject to Evidence of Insurability and can be declined for coverage.
Evidence of Insurability	**You will be required to submit Evidence of Insurability if:** • You declined voluntary life for you or your dependents during your initial eligibility period and would like to enroll for coverage now. You elect to increase your current election.
In order to purchase Voluntary Life for Spouse and Children you must buy coverage for yourself.	

Refer to the benefit summary or certificate of coverage for more information.

Dunn & Assoc. Member Portal

Login- if already registered or follow these instructions to create your account.

Use the online portal for:

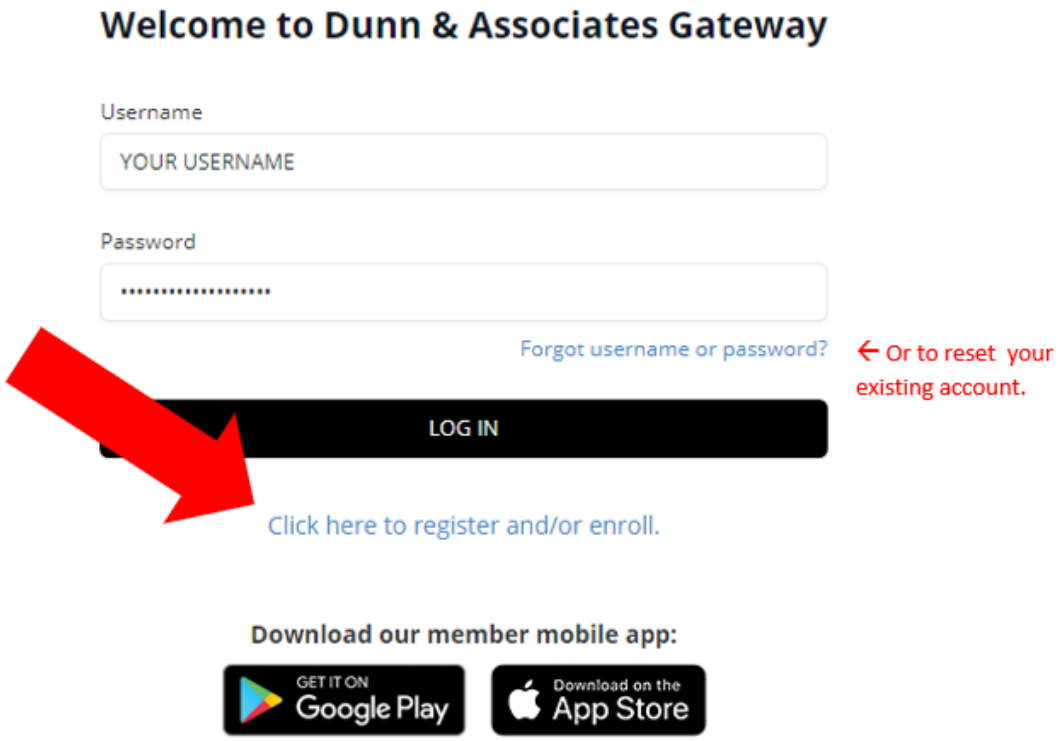
- Access to your explanation of benefits.
- View your year-to-date deductible and out-of-pocket accumulators.

Dunn member portal instructions.
How to create your account.

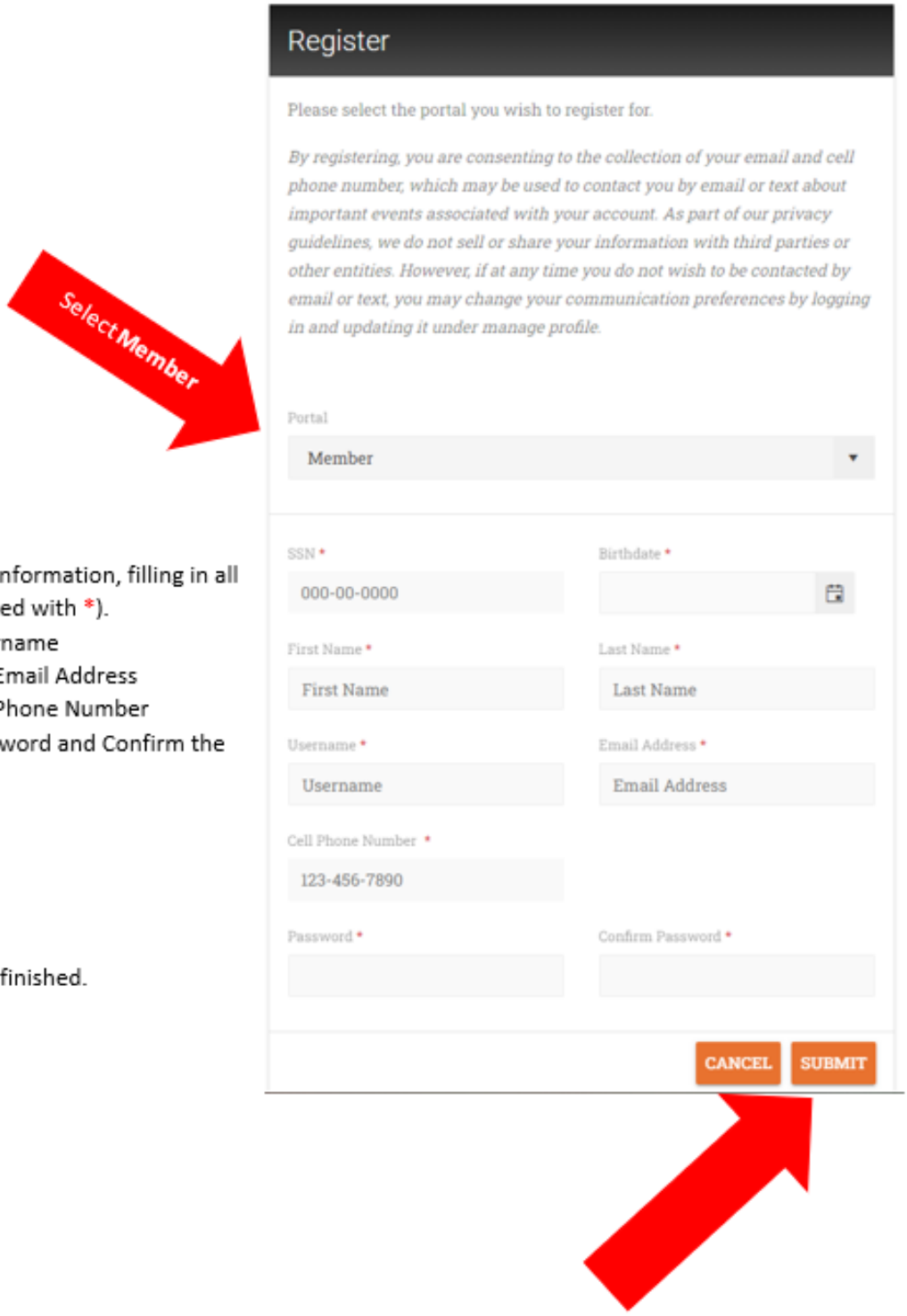
1. Go to www.dunnbenefit.com
2. Click on Login button in upper right hand corner of screen.

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

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



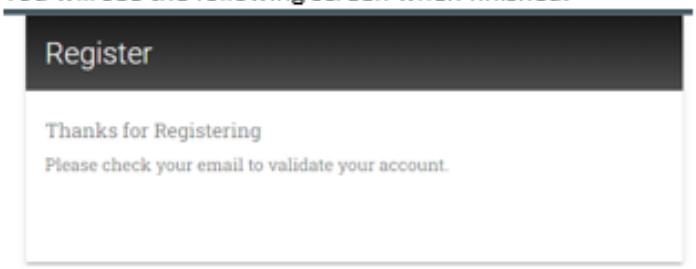
4. Select "Member" from the Portal Drop down box.



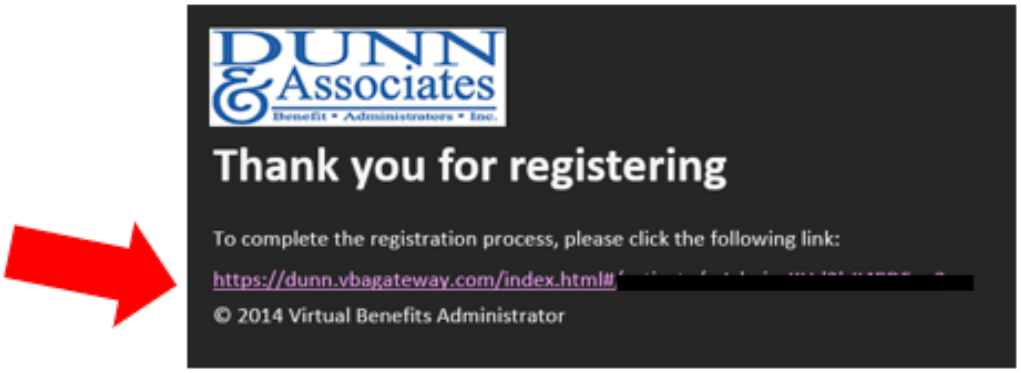
5. Enter your personal information, filling in all required fields (marked with *).
6. Create a unique Username
7. Enter your Personal Email Address
8. Enter your Personal Phone Number
9. Create a unique Password and Confirm the password entered.

10. Click "Submit" when finished.

11. You will see the following screen when finished.

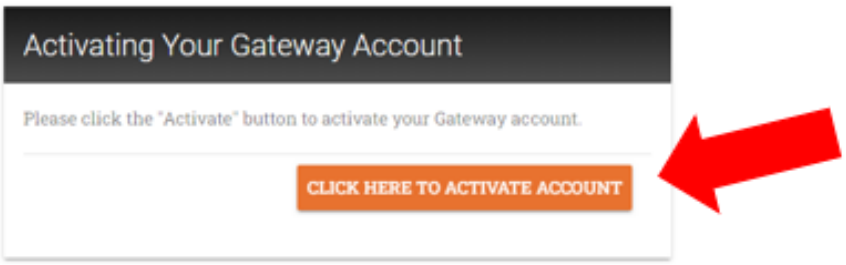


12. **GO TO YOUR EMAIL YOU ENTERED DURING REGISTRATION**, you should see an email similar to the following:

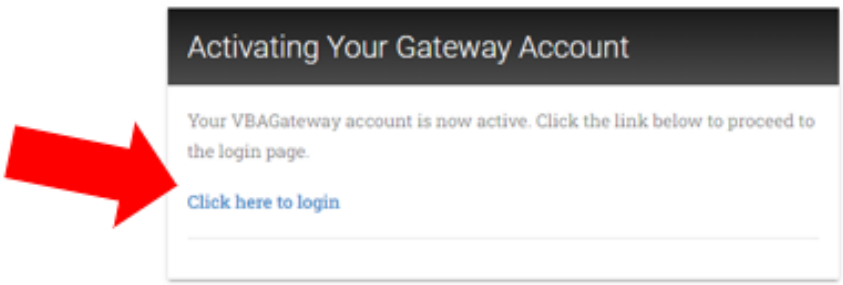


13. Click on the link in your email to complete the registration process.

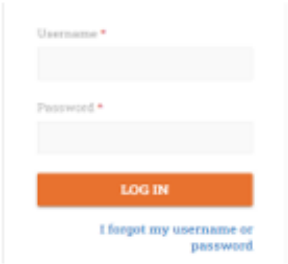
14. Click on the button to activate your account.



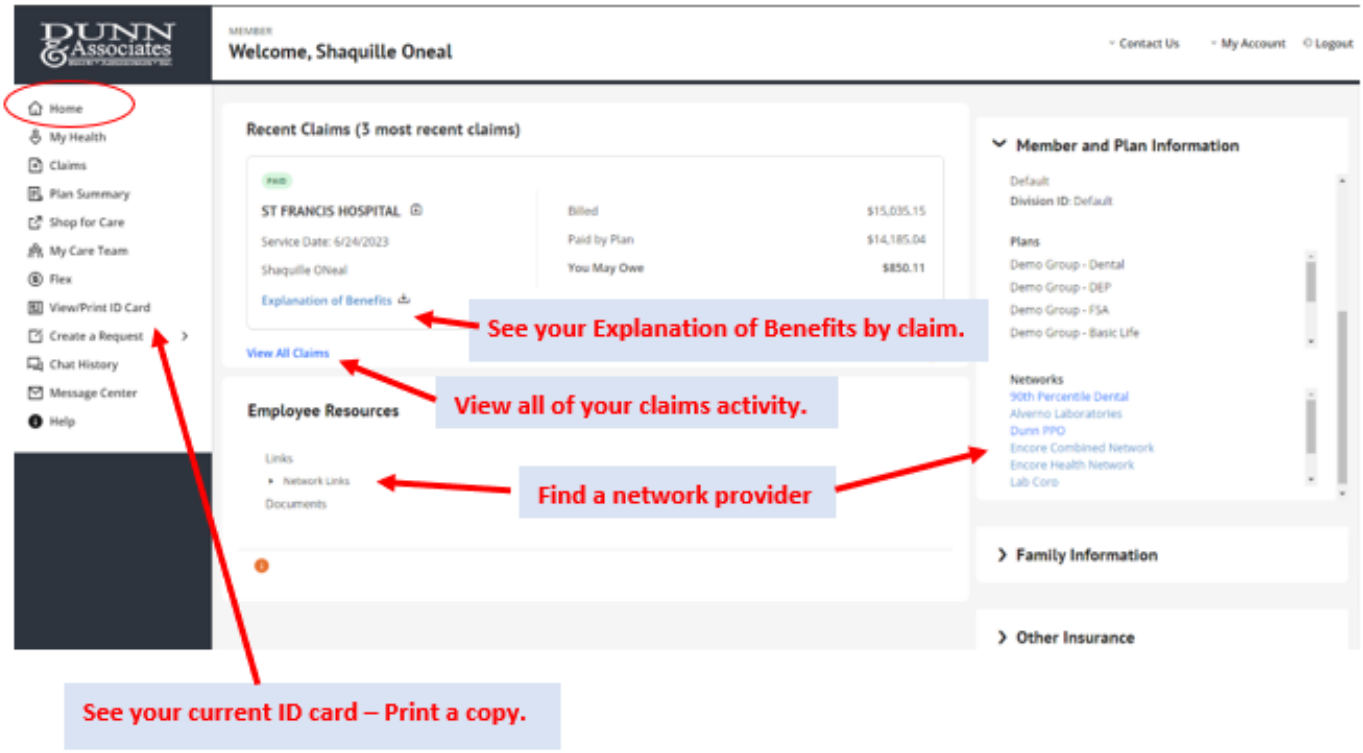
15. Click on the button to go to login.



16. Login using your Username and Password you created during registration.



Once you login, you will see your HOME Screen



Included Required 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 & 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 may also 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 2024
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 than 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 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 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, 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.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace").To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace.

What is the Health Insurance Marketplace?

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

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

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

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit, that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

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

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or cal the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

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.

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 at this job? Julie Nobbe

11. Phone number (if different from above)	12. Email address
	jnobbe@greensburg.in.gov

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.