

City of Greensburg

Employee Benefits

2021

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, 2021. 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.

Rev. 11/02/2020

DUNN & Associates

NEW WALK-IN SERVICE OPTION

AccuDoc Urgent Care (all 3 offices) This Encore Network provider is now your lowest cost option for:

- Office Visit Charge Paid 100%
- Labs Paid at 100% (**Quest lab draw site**) **If you see your regular doctor, request your labs be performed here to save money. Plan pays 100% because labs are much less expensive.**

Additional services:

- $20 X-rays and $5 Allergy shots
- All other services **covered by the plan** 20% coinsurance – Deductible Waived

Encouraged to use the ZipPass feature to minimize wait time.
http://www.accudocurgentcare.com/

(Note: Locations may offer weight loss and other optional community services at this location which are not covered by your plan)

TELEMEDICINE

Still have the Telemedicine option at no cost! 24/7 unlimited access

OTHER LOCAL OPTIONS:

WellClinic *becomes a $20 copay as a DCMH-owned provider in Tier 1 – not 100% in 2018.*

DCMH Owned Doctors *– No Change - remain at $20 copay*

Labs through WellClinic and DCMH Doctors that go through DCMH Hospital: No Change - No Deductible, however ***patient pays 20% coinsurance.***

For no out of pocket cost on labs – Ask your doctor for a lab request form and take it to **any AccuDoc Urgent Care** location or any other designated lab site such as:

Mid-America Labs – Shelbyville and Indianapolis
Sandcrest Labs (Middle Rd behind Rural King) or **PromptMed** (25th St) in Columbus under the CRH lab program

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 Combined facility providers will be paid at the top tier of in-network benefits. Encore providers will be paid at the second tier of in-network benefits.

Area facilities include: Columbus Regional Hospital (Columbus); Community Hospital (Indianapolis); Major Health Partners (Shelbyville); St. Vincent (Indianapolis); IU Medical Center (Indianapolis) and Margaret Mary Hospital (Batesville). You can find additional providers at www.encoreconnect.com.

St. Francis Health is not part of the Encore Network but will be paid as a Tier 1 benefit.

City of Greensburg Schedule of Benefits

Tier 1 = In Network (DCMH, Encore Combined Facilities and St. Francis Facilities) ***Includes IU Health, DCMH, Community, Major, Margaret Mary, Columbus Regional, St. Vincent, St. Frances and more- see packet)***
Tier 2 = In Network (other Encore Facilities and Encore Providers) ***Includes Rush, and other Encore facilities – see packet)***
Tier 3 = Out of Network Facilities/Providers

COMPREHENSIVE MEDICAL BENEFITS (Employee and Dependents)

BENEFIT DESCRIPTION	IN-NETWORK TIER 1	IN-NETWORK TIER 2	OUT-OF-NETWORK TIER 3	PLAN LIMITATIONS
"AccuDoc UrgentCare" Office Visit and Labs **3 offices Greensburg / Batesville / Harrison, (OH)** **Xrays** **Allergy Shots** **Other Services**	100% no deductible Additional Services available at their locations only **$20 copay X-Rays** **$5 copay – Allergy Shots** Plan pays 80% You pay 20%	Not applicable	Not applicable	**Note: "AccuDoc Urgent Care" is their business name for these 3 locations. THIS BENEFIT DOES NOT INCLUDE OTHER BUSINESSES THAT MAY OFFER URGENT CARE TYPE SERVICES.**
Office Visits **Primary Care** **Specialist**	**DCMH Owned Physician & WellClinic** $20 copay	 $25 copay	After Deductible Met **Plan pays 60%** You pay 40%	
Emergency Care **Facility** **Physician**	$150 copay then **80% no deductible** You pay 20%	$250 copay then **70% no Deductible** You Pay 30% After Deductible **Plan pays 70%** You pay 30%	$250 copay then **70% no Deductible** You Pay 30% After Deductible **Plan pays 70%** You pay 30%	
Deductible Individual Family	***No Deductible for services at TIER 1FACILITIES and Decatur Memorial / St. Francis***	$750 $1,750	$1,500 $3,500	In and Out-of-network deductibles accumulate separate. Deductible applies to all covered expenses unless otherwise stated under Special Conditions or elsewhere in this document.
Covered Expenses	No Deductible(waived) **Plan pays 80%** You pay 20%	**After Deductible** **Plan pays 70%** You pay 30%	**After Deductible** **Plan pays 60%** You pay 40%	Unless otherwise stated under Special Conditions or elsewhere in this document.
Medical Coinsurance Limit (per calendar year) Individual Family	*(Most you will pay in coinsurance In Network)* $1,250 $1,750		$2,500 $4,000	In and Out-of-network limits do not apply towards each other. After the coinsurance limit has been met, covered expenses are payable at 100% of reasonable and customary for the remainder of that calendar year. Coinsurance limits include applicable copays.
Rx Coinsurance Limit Individual Family	*(Most you will pay in Rx coinsurance & Copays)* $500 $1,000		$500 $1,000	
Total Out-of-pocket Maximum Individual Family	*(Most you will pay in Deductible / Medical Coinsurance and Rx coins. & copays combined)* $2,500 $4,500		$4,500 $8,500	Total Out-of-pocket Maximum equals the deductible + medical coinsurance + Rx coinsurance. In and Out-of- network accumulate separately.

SPECIAL CONDITIONS				
BENEFIT DESCRIPTION	**IN-NETWORK TIER 1**	**IN-NETWORK TIER 2**	**OUT-OF-NETWORK TIER 3**	**PLAN LIMITATIONS**
Voluntary Second Surgical Opinion	100% no deductible	100% no deductible	100% no deductible	
Pre-Admission Testing	No Deductible(waived) **Plan pays 80%** You pay 20%	After Deductible Met **Plan pays 70%** You pay 30%	After Deductible Met **Plan pays 60%** You pay 40%	
Hospital Room & Board	No Deductible(waived) **Plan pays 80%** You pay 20%	After Deductible Met **Plan pays 70%** You pay 30%	After Deductible Met **Plan pays 60%** You pay 40%	Limited to average semi-private room rate Specialty Care Unit (i.e. intensive, cardiac, or burn care units) 4x semi-private room rate
Mental Health/Substance Abuse Care Inpatient	No Deductible(waived) **Plan pays 80%** You pay 20%	After Deductible Met **Plan pays 70%** You pay 30%	After Deductible Met **Plan pays 60%** You pay 40%	Limited to average semi-private room rate
Outpatient	**With a DCMH Owned Physician** $20 copay	$25 copay	After Deductible Met **Plan pays 60%** You pay 40%	
Home Health Care		After Deductible Met **Plan pays 70%** You pay 30%	After Deductible Met **Plan pays 60%** You pay 40%	Limited to an ANNUAL individual maximum of 100 visits and a maximum of 4 hours per visit.
Skilled Nursing Facility		After Deductible Met **Plan pays 70%** You pay 30%	After Deductible Met **Plan pays 60%** You pay 40%	Limited to an ANNUAL individual maximum of 30 days.
Hospice Care	No Deductible(waived) **Plan pays 80%** You pay 20%	After Deductible Met **Plan pays 70%** You pay 30%	After Deductible Met **Plan pays 60%** You pay 40%	
Preventative Health 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.

SPECIAL CONDITIONS				
BENEFIT DESCRIPTION	**IN-NETWORK TIER 1**	**IN-NETWORK TIER 2**	**OUT-OF-NETWORK TIER 3**	**PLAN LIMITATIONS**
Ambulance Expenses	No Deductible(waived) **Plan pays 80%** You pay 20%	After Deductible Met **Plan pays 70%** You pay 30%	After Deductible Met **Plan pays 60%** You pay 40%	
Physiotherapy Outpatient Care Physical Therapy – Limit 20 visits/yr Occupational Therapy– 20 visits/yr Manipulative Therapy – 12 visits/yr Speech Therapy – 20 visits/yr Cardiac Rehab – 36 visits/yr Pulmonary Rehab – 20 visits/yr	No Deductible(waived) **Plan pays 80%** You pay 20%	After Deductible Met **Plan pays 70%** You pay 30%	After Deductible Met **Plan pays 60%** You pay 40%	Annual limits on number of visits apply.
Medical Aids	No Deductible(waived) **Plan pays 80%** You pay 20%	After Deductible Met **Plan pays 70%** You pay 30%	After Deductible Met **Plan pays 60%** You pay 40%	
Temporomandibular Joint (TMJ) **Expenses**	No Deductible(waived) **Plan pays 80%** You pay 20%	After Deductible Met **Plan pays 70%** You pay 30%	After Deductible Met **Plan pays 60%** You pay 40%	
Laboratory Expenses Note: "AccuDoc Urgent Care" is a Designated Facility (Quest) Plan pays 100%. **(At DCMH / WellClinic you will continue to pay 20% Coinsurance when billed through DCMH)**	No Deductible(waived) **Plan pays 80%** You pay 20%	Through Designated Facility 100% no deductible Any Other Facility After Deductible Met **Plan pays 70%** You pay 30%	After Deductible Met **Plan pays 60%** You pay 40%	Designated Draw Sites include: All Quest/LabOne sites – Including these **local locations:** **"AccuDoc Urgent Care"** in Greensburg and Batesville **Mid-America Labs** – Shelbyville and Indianapolis **CRH lab sites** **PromptMed/ Sandcrest Labs** -Columbus
Cardiovascular (Heart) **Care** .	No Deductible(waived) **Plan pays 80%** You pay 20%	Premier Healthway Heart Program 100% no deductible Any Other Facility After Deductible Met **Plan pays 70%** You pay 30%	After Deductible Met **Plan pays 60%** You pay 40%	**Premier Healthway Heart Program** St. Francis is a designated facility. You must identify yourself as part of the Premier Healthway program by showing your Insurance card sleeve.
Organ Transplants				Refer to the fully-insured transplant policy for primary benefits.
Dialysis In-patient or Out-patient	No Deductible(waived) **Plan pays 80%** You pay 20%	After Deductible Met **Plan pays 70%** You pay 30%	After Deductible Met **Plan pays 60%** You pay 40%	Payable at 150% of Medicare Fee Schedule Limited to 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.

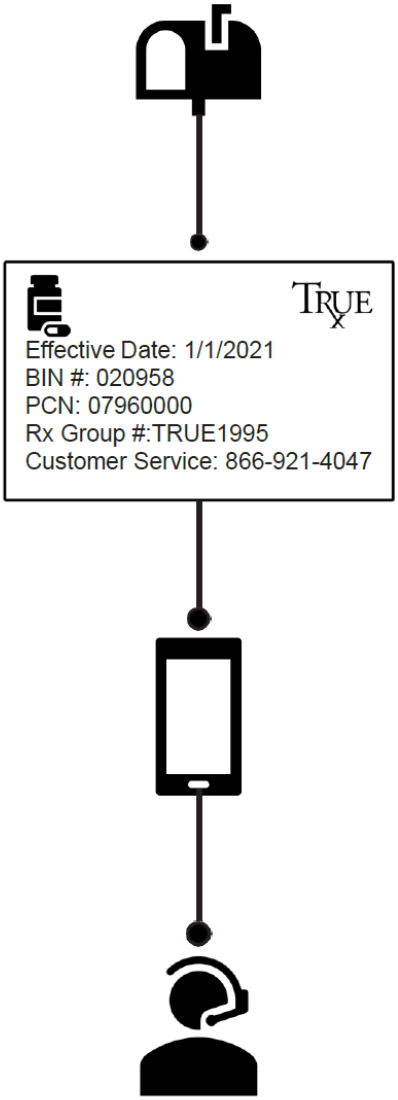
PHARMACY BENEFITS			
Prescription Drug Benefit			
Retail Program	Employee Pays		
(30-day supply)			
Tier 1 Generic Drugs	$4.00	Not Applicable	Deductible waived when Network Pharmacy utilized.
Tier 2 Brand Name/Preferred	$35.00		
Tier 3 Brand Name/Non-Preferred	$75.00		If an insured elects not to purchase a generic drug when available and approved by the physician, the employee will be responsible for the applicable brand copay plus the difference in the cost of the generic and the brand name drug purchased.
Tier 4 Specialty	25% Max. $200 without assistance		
Mail Order Or **Retail**			
(90-day supply)			
Tier 1 Generic Drugs	$10.00		
Tier 2 Brand Name/Preferred	$70.00		
Tier 3 Brand Name/Non-Preferred	$150.00		
Tier 4 Specialty	See Retail, 30-day supply maximum		*Specialty Rx – January 1, 2021* Coverage available only if the patient does not qualify for patient assistance program. Specialty drugs limited to 30-day supply.

EFFECTIVE JANUARY 1, 2021 YOU DRUG PROGRAM WILL BE WITH TRUE RX.
See below for additional information.

City of Greensburg
BIN #: 020958
PCN: 07960000
Rx Group Number: TRUE1995
Rx Member Service: 866-921-4047
Pharmacy Helpdesk: 833-202-8783
www.truerx.com

Your Pharmacy Insurance Benefits

True Rx has partnered with your employer to provide you with pharmacy insurance benefits. In order to activate your benefits, please take these three steps.



1. FIND YOUR NEW CARD IN THE MAIL.

You will receive a new insurance card from Dunn & Associates

This card ensures the amount you pay for your medications at the pharmacy is accurate with your insurance plan.

2. TAKE YOUR NEW CARD TO THE PHARMACY.

If you need to fill a prescription and do not have your new insurance card, please bring this document to the pharmacy.

3. UPDATE YOUR MAIL ORDER PRESCRIPTION.

If your plan allows for mail order service and you would like to continue to receive medications mailed to you, please contact Postal Prescription Services. You can complete this process online at www.ppsrx.com or call PPS at 800-552-6694.

YOUR SECURE INFORMATION IS AVAILABLE 24/7.

Sign into the secure portal at www.truerx.com or download the app.

- View your ID card
- Find your member ID number
- Locate pharmacies in your network
- See current prescriptions
- Compare medication pricing

YOU HAVE A PRESCRIPTION PLAN EXPERT TO CALL.

You have a team of experts in prescription benefit plans ready to help.

- Call True Rx at 866-921-4047
- Monday – Friday
- 8:00am – 6:00pm EDT

On behalf of all of us at True Rx, we look forward to taking care of your pharmacy insurance needs.

866-921-4047 | www.truerx.com

TRUE Rx

Online and Mobile App

Benefit information is available through a secure member portal at www.truerx.com and in the True Rx app. If you have questions, please call True Rx at 866-921-4047.

ACCESS TO THE MOBILE APP IS SIMPLE.

1. **REGISTER** online at www.truerx.com/member-portal.
2. **RECEIVE** a confirmation email with your username and password.
3. **DOWNLOAD** the app by searching True Rx.
4. **ENTER** your username and password.

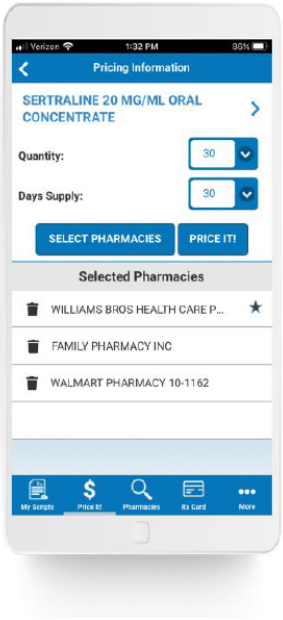
YOUR SECURE ONLINE ACCESS OFFERS:

CLAIM HISTORY

View prescription claims paid by your plan.

COVERAGE LIMITS AND PAYMENT DETAILS

View your pharmacy claim deductible information or coverage phase.



DRUG INFORMATION

With the drug dictionary, compare drugs for possible interactions or side effects.

DRUG PRICING

Your specific insurance copay or co-insurance is displayed.

Compare prices at multiple pharmacies.

PHARMACY LOCATOR

Identify pharmacies with addresses, maps, phone numbers, and hours.

RX CARD

Easy access to your prescription insurance card.

Mail Order Prescription Benefits

Your pharmacy insurance plan offers the convenience of a 90-day supply of medications delivered to your home through Postal Prescription Services (PPS), a mail order pharmacy.

YOUR ONLINE ACCOUNT WITH PPS

1. Go to ppsrx.com and select the "Create an Account" option in the lower left-hand corner.
2. Enter your email address and create a password.
3. Select "Create Account".
4. Connect account to a patient profile for yourself or someone you wish to manage on the "Add a Patient" page of the website.
5. New Patients - If you have not filled a prescription with PPS or The Kroger Family of Pharmacies, you will need to fill out a new patient request form by selecting "Request New Patient".
6. Follow the steps to set up your patient profile and request your first prescription fill. You will be able to "Add Online Prescription Management" once you have your PPS prescription number.

ONLINE ORDERING NEW OR TRANSFERRED PRESCRIPTIONS WITH PPS

You have three ways to order new or transferred prescriptions. Generally, it takes 3-5 business days for PPS to contact your prescriber or pharmacy to obtain your prescription(s).

1. Once you have created an account, you can select "Add a Prescription" from the left navigation menu and follow the on-screen steps for PPS to request a new prescription from your doctor or a transferred prescription from another pharmacy.
2. Create an online account and ask your doctor to send a new prescription to PPS by electronic prescribing, phone, or mail.
3. If your doctor gives you a paper prescription, create your online account at ppsrx.com and mail the paper prescription to PPS at:

   PPS Prescription Services
   PO Box 2718
   Portland, OR 97208-2718

PAYMENT OPTIONS

PPS accepts MasterCard, Visa, Discover, American Express, personal checks, and money orders. If you are paying by check or money order, PPS must receive these forms of payment prior to shipping your order. You can add or update credit card information from your "Cart" when checking out.

Please contact PPS customer service at 800-552-6694 for assistance.
Customer service hours are Monday - Friday, 6am - 6pm PST and Saturday, 9am - 2pm PST.

Frequently Asked Questions

OUR EXPERTS ARE HERE TO HELP.

True Rx customer service representatives have extensive training in prescription plan coverage and can answer your questions. Please contact True Rx at 866-921-4047.

DO I NEED TO CHANGE PHARMACIES?

More than 65,000 pharmacies are included in the True Rx Pharmacy Network, including national chains and independent pharmacies. Download the True Rx app to view the pharmacy locator map in your area.

HOW DO I FILE A PRESCRIPTION CLAIM IF I DIDN'T USE MY ID CARD AT THE PHARMACY?

Mail a completed True Rx Drug Claim Form found at www.truerx.com and your pharmacy receipt(s) to:
True Rx
7 Williams Bros. Drive
Washington, IN 47501

WHAT IS A PA?

PA means prior authorization. Some medications require a PA by True Rx because the prescription needs reviewed for medical necessity and to ensure it is the most appropriate medication for you.

DO I HAVE TO USE GENERIC MEDICATION?

It depends on your plan. If your employer has chosen to have generic medications preferred or required and you choose to have the brand name medication, you can still receive the brand name medication. However, you may need to pay the brand copay plus the difference in cost between the brand name and the generic drug unless the prescription states "dispense as written" or "no substitution" by your medical provider.

WHAT IS STEP THERAPY AND HOW DO I KNOW IF IT AFFECTS ME?

Step therapy means the prescribed medication has safe and effective alternatives that cost less than the originally prescribed medication. Step therapy is not for every medication and not every insurance plan includes it.

WHAT IS A SPECIALTY DRUG?

Specialty medications treat complex conditions such as cancer, rheumatoid arthritis, and multiple sclerosis. These medications typically require close monitoring and special handling, so they are usually only available through a specialty pharmacy. Specialty medications are limited to a 30-day supply and require a PA. If you are taking a specialty medication, a trained specialty case manager can assist you with the transition to True Rx.

On behalf of all of us at True Rx, we look forward to taking care of your pharmacy insurance needs.

866-921-4047 | www.truerx.com

Swift MD (online passcode: !CTYGRN17)

SwiftMD's telemedicine service is included in your healthcare benefits package.

This benefit is provided at **NO COST TO YOU!**

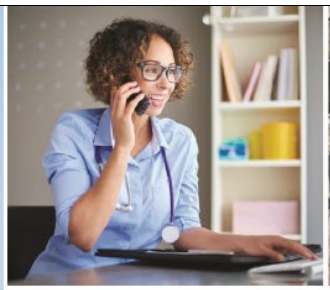
You can talk to a doctor 24/7, and when you schedule a consult you will get a callback within the hour.

Just login at **mySwiftMD.com**, or call **833-SWIFTMD** (833-794-3863) or 877-999-7943.

CONDITIONS WE TREAT*

Allergies
Fever and flu
Headache
Insect bites and stings
Pink eye
Prescriptions when appropriate
Rashes
Sinusitis
Sore throat
Upper respiratory infections
Upset stomach
Urinary tract infections
Vomiting
Your individual medical concerns

**SwiftMD does not replace your PCP or specialists managing chronic and serious conditions.*



Healthcare on Demand

SwiftMD is a telemedicine service that delivers quality health care directly to patients in need. Members enjoy access to quality, convenient medical care over the phone or videoconference, 24/7 —at no cost for co-pays or consult fees.

Benefits Include:

- 24/7/365 nationwide access to U.S. Board-Certified physicians
- Consults with doctors via phone or videoconference; doctor makes diagnosis and recommends treatment
- Doctor calls in prescription when appropriate
- Members can avoid unnecessary visits to the ER, or long waits for an appointment at your doctor's office
- **No Co-Pays and No Cost to You!**

SwiftMD Physicians

Quality physicians are at the core of what we do.

We employ exclusively U.S.-trained, Board-Certified Emergency and Family Practice doctors. Our doctors:

- Are U.S.-trained in Emergency or Family Medicine, and are Board-Certified.
- Have a minimum of 10 years' experience practicing medicine.
- Are trained in telemedicine.
- Are experienced at diagnosing a range of illnesses and injuries.

While Swift MD can provide many healthcare services to you at your convenience, it is not designed to replace your Primary Care Physician or Specialists managing chronic illnesses or serious medical conditions. For more information, please refer to the Exclusionary Criteria posted on mySwiftMD.com.

To Access your SwiftMD Account

- Simply call our toll-free phone number: **833-SWIFTMD (794-3863).** Your membership will be verified, and then your appointment will be scheduled. Receive a call back within 30 minutes of scheduling your appointment.

Or

- Access your membership online (optional);
- Go to mySwiftMD.com and click "Get Started"
- Click "Lookup Account with Group Passcode"
- Enter Group Passcode, name, birth date and email address
- SwiftMD will email your username and password; be sure to log on to complete activation

SWIFT MD®
Talk to a Doctor 24/7!

DELTA DENTAL

Voluntary Benefits

Delta Dental Contributions	Monthly Premium	Cost per Pay (48)
Employee	$ 29.87	$ 7.47
Employee + 1	$ 57.76	$ 14.44
Employee + 2 or more	$ 115.85	$ 28.97

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

Delta Dental PPO (Point-of-Service) *Coverage effective **January 1, 2021***	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 -	up to age 19	up to age 19	up to age 19

** 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 or Delta Dental approves and you are responsible for that difference.*

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

Deductible – $50 Deductible per person 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 person is enrolled in the dental plan for 12 consecutive months. Orthodontic Services will not be covered until after a person 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.*

DELTA DENTAL

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 Consumer Toolkit 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.

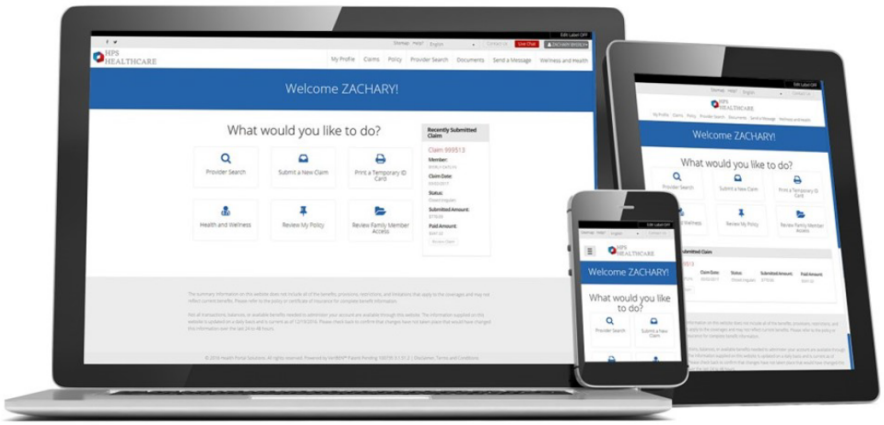
Questions?

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	Monthly Premium	Cost per Pay (48)
Employee	$10.21	$2.55
Employee + 1	$15.58	$3.90
Employee + 2 or more	$27.93	$6.99

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	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate 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 20-25% on other lens enhancements	$55 $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
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	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		

DUNN & Associates
Benefit ▪ Administrators ▪ Inc.



Check out your new member portal!

Easily manage your healthcare and plan benefits online.

- **Mobile Access:** No app needed! Just log in from the browser on your mobile device, and the portal will resize to fit your screen.
- **Print ID Card:** Whether it's printing or showing your ID card from your phone, this tool will save you time and space in your wallet.
- **New User-Friendly Design:** It's easier to navigate our portal and find the information you need.
- **Personal Health Record:** Upload all your important medical documents into our secure, HIPAA-compliant portal. You can even share them with your doctor.
- **Online Enrollment:** No more sifting through stacks of forms! Our online tool gets you through the enrollment process in minutes.

Create Your Account Today!

Log in: www.dunnbenefit.com

Or scan this code with your mobile device:

Your Online Benefits Center

The Dunn & Associates portal is **your go-to place** for your important benefit-related information, including:

1. Claims
2. Benefit Plan Details
3. Prescription Info
4. Telemedicine
5. Daily Health & Wellness Videos



The Dunn & Associates portal is **accessible from your mobile device** and saves you from remembering multiple usernames and passwords.

Save Time Online!

Your new member portal is a big **time-saver** when it comes to managing your benefits. Take care of all these benefit-related tasks with one login:

1. Enroll Online
2. Search for a Doctor
3. Request an ID Card
4. Access Plan Documents
5. Email us or your HR



What are you waiting for? **Create your account today** and begin experiencing an easier way to manage your benefits!

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.

Extension of Dependent Coverage to Age 26
The adult child will be eligible under this plan, regardless of whether the adult child is eligible to enroll in another employer-sponsored health plan. A plan that covers the adult child as an employee or spouse will be primary to this plan which 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 800-880-9960 or visit www.dunnbenefit.com.

Grandfathered Plan Status
This plan is considered to be a "Non-Grandfathered Plan" under the PPACA. Being a non-grandfathered plan means that the Plan includes certain consumer protections of 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 grandfathered health plan status can be directed to Dunn and Associates Benefit Administrators at 812-378-9960 or 800-880-9960. The Plan participant may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa.

Prohibition on 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 group health plans 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 Noticed about Your Prescription Drug Coverage and Medicare

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. 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.

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 October 15th through December 7th. 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.

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, visit www.medicare.gov .

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:

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).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	November 2020
Name of Entity/Sender:	City of Greensburg
Contact--Position/Office:	Julie Nobbe
Address:	314 W. Washington Greensburg, IN 47240
Phone Number:	812-663-8582

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) was signed into law on October 21, 1998. The law requires that Employees are notified of the Maternity and Mastectomy benefits it encompasses periodically.

Maternity Benefits (Precertification)
The Department of Labor (DOL) has issued an interim regulation that modifies the Newborns' and Mothers' Health Protection Act of 1996. The Newborns' and Mothers' Health Protection Act generally prohibits health insurance issuers and group health plans from restricting benefits for hospitalization 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. The DOL's interim regulation further clarifies (or modifies) this act by stating that Federal law generally does NOT prohibit the mother or newborn's attending health provider from discharging the mother or her newborn earlier than 48 hours after vaginal delivery or 96 hours after cesarean section when the provider has consulted with the mother first.

Mastectomy Surgery (*Related Services Covered)*
The Women's Health and Cancer Rights Act of 1998, enacted as part of the Omnibus Budget Bill, requires that group health plans providing coverage for a mastectomy to also cover additional related charges. We are pleased to say that your plan does provide coverage for mastectomies; therefore, the following related services are now also covered under your plan:
Breast reconstruction of a surgically removed breast
Surgery and reconstruction of the other breast to produce a symmetrical appearance
Prostheses and treatment for physical complications from all stages of mastectomy, including lymphedemas
Applicable copayments and deductibles apply to these services as indicated in your Summary Plan Description.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of 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

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
- 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
- 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.

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)

Complaint forms are also available at *http://www.hhs.gov/ocr/office/file/index.html*

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

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

.

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.

[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 City of Greensburg		4. Employer Identification Number (EIN) 35-6001049
5. Employer address 314 w Washington St.		6. Employer phone number (812) 683-8582
7. City Greensburg	8. State IN	9. ZIP code 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.