Southeast Dubois County School

Open Enrollment Guide

January 1, 2023

Every step has been taken to ensure the information in the booklet is correct. Unfortunately, inaccuracies can occur. It is necessary to read the Summary Plan Description (SPD) booklet for complete details of the benefits provided. If there is a conflict in terms of benefits described, the SPD will supersede in determining benefits paid. Again, this is only a brief description of your benefits, please read the SPD for complete details.

Introduction

Southeast Dubois County Schools along Dunn & Associates have worked collectively to develop an impressive health plan for all eligible employees and their eligible dependents. We are committed to providing plan participants with access to great benefits. This packet has been designed to help you make decisions about your benefits.

This booklet provides information to help you enroll into the benefits plan. Please complete the online enrollment as soon as possible. If you have difficulty completing the form or have questions about the benefits, deductions or other benefit related matters, please don't hesitate to call Tracy Troesch or Dunn & Associates.

Contact Information

Southeast Dubois County School
Tracy Troesch
432 E 15th St.
Ferdinand, IN 47532
PH: (812) 817-0900
tracy.troesch@sedubois.k12.in.us

Administrator

Dunn & Associates Benefit Administrators, Inc.
4550 Middle Rd. Suite A
PO Box 2369
Columbus, IN 47202-2369
PH: (812) 378-9960
FX: (812) 378-9967
www.dunnbenefit.com

For Questions please contact;

Anne Koontz, Benefit Analyst	akoontz@dunnbenefit.com
Tammy Shaw, Claims Manager	tshaw@dunnbenefit.com

Dunn Online

Dunn & Associates is committed to "personal touch" customer service; however, we know that some people also want to have the option of obtaining information concerning their benefit plan via the Internet. For this reason, we offer "Dunn Online". Visit www.dunnbenefit.com. Please visit our website www.dunnbenefit.com for additional access to claims; benefit information; or help in answering any questions.

Open Enrollment

An open enrollment period shall be held annually during the month of October/November. During this open enrollment period, employees who have not previously elected coverage under the Plan and who do not qualify for a Special Enrollment period as described herein, may enroll for coverage for themselves and/or any eligible dependents. Coverage shall be effective on January 1 for employees or dependents that enroll during an open enrollment period.

During open enrollment you may;

1. change your plan elections for medical
2. add/delete coverage for your spouse or dependent children;

If you do not finalize the open enrollment procedures, your coverage elections from the previous year will remain in effect for the health insurance coverage.

If you wish to continue your current elections with no changes,
NO ACTION IS REQUIRED!

2023 Open Enrollment Instructions:

Beginning November 1st to November 18th, 2022: Login to make changes for 2023

- Elections will be effective January 1, 2023.
- If you wish to continue your current elections with no changes, NO ACTION IS REQUIRED!
- If you wish to make changes to your current enrollment elections:
  - Go to www.dunnbenefit.com
  - Click Login
  - Choose Enrollment Tab
  - Choose Start Enrollment
  - Choose Annual Enrollment – proceed with elections

Eligibility

ELIGIBILITY FOR EMPLOYEES

All full-time Employees will be eligible for coverage. Full-time is defined as employees who are scheduled to work 30 hours per week at the usual place of business or the location to which you are required to travel. No person may be both an employee and a dependent of this Plan.

ELIGIBILITY FOR DEPENDENTS

An Employee may request coverage for his/her eligible dependents. The cost of the premium for this coverage is the Employee's responsibility. All dependents must meet the criteria listed in the Definitions section to be eligible for coverage.

All eligible dependents will commence coverage on the day the Employee does if written application has been made on or before the effective date. If the Employee makes a written request for coverage after the effective date on which he is eligible for dependent coverage, those persons who are his dependents shall be considered "Late Enrollees" and, coverage shall not become effective until the next Open-Enrollment period.

Special Enrollment Period (CHIP)

Effective April 1, 2009, when an employee or eligible dependent is covered under a Medicaid plan or states children's health insurance program (CHIP) and loses eligibility under that plan; or becomes eligible under a CHIP or Medicaid plan for premium assistance that could be used toward the cost an employer health plan, may be able to enroll within 60 days of losing coverage

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 through this plan. The Working Spouse Rule does not require a spouse to enroll in his/her employer's plan. However, if the spouse is eligible to enroll, there will be no coverage under this plan. Mini-med or Limited Benefit plans with less than $10,000 annual coverage will not be considered insurance coverage under this provision.

WAITING PERIOD

All eligible employees will commence coverage on the first day of the month following employment for this Employer if the Employee has agreed to make any required contributions for coverage (but not until an enrollment form has been completed and signed).

EFFECTIVE DATE

All eligible employees shall become effective after the stated waiting period provided written application for such coverage is made on or within 30 days of such date. If application is made after the initial date of eligibility (other than during a special enrollment period available to special enrollees), the Employee shall be considered a Late Enrollee and, coverage for the eligible employee shall not become effective until the end of the next Open-Enrollment period. As of September 1, 2014, this plan will not deny any claims due to a pre-existing condition. Proof of prior coverage is no longer required by this plan.

MAKING CHANGES THROUGH OUT THE YEAR

The elections you choose during open enrollment will be in place from January 1 to December 31, 2022. Changes to these elections may require a qualifying event. In the case of a qualifying event, contact Human Resources within **30 days** of the event. *If you don't make the changes within the 30 days, you will have to wait until the next open enrollment period*.

Qualifying Events (recognized by the IRS):

- Birth/Adoption
- Death
- Marriage/Divorce/Legal Separation
- Loss of Coverage

General Information

IDENTIFICATION CARD

Each employee enrolling for the first time will receive an I.D. card. Families will receive two cards. If additional cards are needed for high school age or college-age dependents, please call your Human Resources Department or Dunn & Associates and additional cards will be provided.

DRUG PROGRAM

Your drug program is administered through **True Rx**. You will be able to pay a co-pay at the time of purchase at network pharmacies. It will not be necessary to file a claim form with our office. Drug program information is included on your ID card. You may contact True Rx Member Services at (866) 949-4405 or you can visit their website at www.truerx.com

SUBMISSION OF CLAIMS

In most cases, hospitals and doctors directly bill to the address on the back of your I.D. Card. Claims forms will not be necessary in these cases. If you wish to submit the claim yourself, claim forms will be available from the Human Resources Department or at Dunn and Associates. The claims should be mailed to the address on back of I.D. Card.

PPO NETWORK:

PRIMARY
In Indiana – PVHCC

SECONDARY
Outside of Indiana – United HealthCare

Your plan utilizes the Patoka Valley Health Care Cooperative (PVHCC) network. This network includes providers in your area. If you have any questions concerning the status of a provider in the network or need a referral to use a provider outside of the PVHCC network, please feel free to contact PVHCC directly at (812) 683-3332. PVHCC can also be seen at www.pvcooperative.com.

Effective January 1, 2023, United HealthCare network will be utilized for claims outside of PVHCC network. More information and new ID Cards will be provided before January 1, 2023.

PRECERTIFICATION

Call CLINIX (800) 227-2298 prior to receiving the following services to receive maximum benefits payable under the plan. For complete details concerning pre-certification requirements, please refer to your ID card and/or Summary Plan Description booklet.

Employee Contributions

Medical Benefits coverage is available through Dunn & Associates. Southeast Dubois County School provides this coverage to all eligible employees. The cost of this coverage is:

	$3,000 Deductible	**$5,000 Deductible**
Per Pay (24 pays – bi-weekly)		
Single	$108.00	$25.00
Employee + Child(ren)	$284.00	$80.00
Employee + Spouse	$328.00	$85.00
Family	$452.00	$100.00

A Summary of Benefits and Coverage (SBC) included in this packet for details regarding your medical plan benefits. As stated before, every step has been taken to ensure the information in this booklet is correct. Unfortunately, inaccuracies can occur. If there is conflict in terms of benefits described, the SPD will supersede in determining benefits paid. For a copy of your most recent SPD and any applicable amendments, please check out www.dunnbenefit.com.

Schedule of Benefits

COMPREHENSIVE MEDICAL BENEFITS (Employee and Dependents)					
	PLAN A **High Deductible Health Plan (HDHP)** may be elected with or without a Health Savings Account (HSA)		**PLAN B** **High Deductible Health Plan (HDHP)** may be elected with or without a Health Savings Account (HSA)		**PLAN A & B**
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Plan Status	Non-Grandfathered		Non-Grandfathered		
Annual Maximum (per individual)	Unlimited				Some covered expenses have separate annual and/or lifetime maximums as stated under Special Conditions.
Pre-utilization	See pre-utilization section				A $250 reduction in benefits will apply if pre-utilization requirements not met.
Deductible (per calendar yr) Individual Family	 $3,000 $6,000	 $6,000 $12,000	 $5,000 $10,000	 $10,000 $20,000	Deductible applies to all covered expenses unless otherwise stated under Special Conditions. In & Out-of-network deductibles do not apply towards each other. Embedded Deductibles.
Covered Expenses	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Unless otherwise stated under Special Conditions.

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BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Coinsurance Limit Medical Individual Medical Family Rx Individual Rx Family Total Coinsurance Limit Individual Family	 $4,000 $8,000 $0 $0 $4,000 $8,000	 $8,000 $16,000 $0 $0 $8,000 $16,000	 $0 $0 $0 $0 $0 $0	 $0 $0 $0 $0 $0 $0	Per calendar year; In- and out-of-network coinsurance limits do NOT include deductibles and do NOT apply toward each other. After the coinsurance limit has been met, most covered expenses are payable at 100% of reasonable and customary for the remainder of that calendar year. Coinsurance limits include applicable copays.
Total Out-of-Pocket (per calendar yr) Individual Family	 $7,000 $14,000	 $14,000 $28,000	 $5,000 $10,000	 $10,000 $20,000	
Physician Office Visit (Primary Care Physician Only)	80% after deductible	50% after deductible	100% after deductible	50% after deductible	
Outpatient Surgery	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Includes facility and all professional fees.
Voluntary Second Surgical Opinion	80% after deductible	50% after deductible	100% after deductible	50% after deductible	
Hospital Room & Board Intensive Care	80% after deductible 80% after deductible	50% after deductible 50% after deductible	100% after deductible 100% after deductible	50% after deductible 50% after deductible	Limited to semi-private room rate Limited to 4 times semi-private room rate

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Mental Health/Substance Abuse Care (In and Outpatient)	80% after deductible	50% after deductible	100% after deductible	50% after deductible	
Preventative Health Care	100% no deductible	50% after deductible	100% no deductible	50% after 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.					
Physiotherapy Outpatient Care	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Limited to an ANNUAL individual maximum of 30 visits. Therapy includes Physical, Speech, Occupational, Cardiac Rehab and ABA therapy.
Home Health Care	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Limited to an ANNUAL individual, maximum of 100 visits within any calendar year, maximum of 4 hours per visit.
Laboratory Expenses At Designated Facility All Other Facilities	 100% after deductible 80% after deductible	 50% after deductible	 100% after deductible 100% after deductible	 50% after deductible	Call Dunn and Associates for information on designated facilities in your area.
Extended Care/Skilled Nursing Facility	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Limited to an ANNUAL individual maximum of 60 day per convalescent period.
Temporomandibular Joint Disorder	80% after deductible	50% after deductible	100% after deductible	50% after deductible	

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BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Fully-Insured Organ Transplant Policy	See comprehensive medical benefits section of this booklet for additional information. Please refer to the Fully insured organ transplant policy certificate. Pre-utilization requirements must be followed and met or there will be a penalty applied.				
Transportation	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Limited to a maximum of $5,000 per trip.
Emergency (Accident/Illness)	$150 copay then 80% after deductible	$150 copay then 80% after deductible	100% after deductible	100% after deductible	
Cash Reward Program	50% of actual savings	50% of actual savings	50% of actual savings	50% of actual savings	Limited to a per occurrence maximum of $500.
Dialysis	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Maximum allowable amount is 200% of the Medicare allowable for incurred expenses. 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 outpatient treatment.
Foot Care	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Limited to an ANNUAL individual maximum of $500.

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BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Prescription Drug Benefit					If the insured elects not to purchase a generic drug when available and approved by the physician, the employee will be responsible for the brand copay plus the difference in the cost of the generic and the brand name drug purchased. Discounts are available through pharmacies participating in Preferred network. Only the copay will need to be paid by the covered person up front.
	Copay Employee Pays – AFTER DEDUCTIBLE		Copay Employee Pays– AFTER DEDUCTIBLE		
Retail Store (30-day supply)					
Generic Drugs	$10 after deductible		0% after deductible		
Brand Preferred	$40 or 20% (greater of) maximum of $50 after deductible		0% after deductible		
Brand Non-Preferred	$60 or 30% (greater of) maximum of $150 after deductible		0% after deductible		
Retail Store (90-day supply)	Copay Employee Pays– AFTER DEDUCTIBLE		Copay Employee Pays– AFTER DEDUCTIBLE		
Generic Drugs	$12 after deductible		0% after deductible		
Brand Preferred	$60 or 20% (greater of) maximum of $100 after deductible		0% after deductible		
Brand Non-Preferred	$100 or 30% (greater of) maximum of $200 after deductible		0% after deductible		
	Copay Employee Pays– AFTER DEDUCTIBLE		Copay Employee Pays– AFTER DEDUCTIBLE		
Specialty Program (30-day supply)	*Specialty Rx Coverage available only if the patient does not qualify for patient assistance program.*		*Specialty Rx Coverage available only if the patient does not qualify for patient assistance program.*		
Tier 1	10% without assistance - after deductible		0% without assistance - after deductible		
Tier 2	20% (max $550) without assistance - after deductible		0% (max $550) without assistance - after deductible		
Tier 3	20% without assistance - after deductible		0% without assistance - after deductible		
Tier 4	50% without assistance - after deductible		0% without assistance - after deductible		
	Plan A: Embedded deductible/out of pocket maximum, if a member has family coverage, any combination of covered family members can help meet the family deductible/out of pocket maximum up to each person's individual deductible/out of pocket maximum.		Plan B: Embedded deductible/out of pocket maximum, if a member has family coverage, any combination of covered family members can help meet the family deductible/out of pocket maximum up to each person's individual deductible/out of pocket maximum.		
HIGHER COPAYS WILL APPLY IF THE PRESCRIPTION IS FILLED AT CVS, WALGREENS OR RITE AID PHARMACY.					
Prescription Drug Benefit					
	Copay Employee Pays– AFTER DEDUCTIBLE		Copay Employee Pays– AFTER DEDUCTIBLE		
Retail Store (30-day supply)					
Generic Drugs	$25 after deductible		$0 after deductible		
Brand Preferred	$55 or 25% (greater of) maximum of $65 after deductible		$0 after deductible		
Brand Non-Preferred	$75 or 35% (greater of) maximum of $165 after deductible		$0 after deductible		
Retail Store (90-day supply)	Copay Employee Pays		Copay Employee Pays		
Generic Drugs	$27 after deductible		$0 after deductible		
Brand Preferred	$75 or 25% (greater of) maximum of $115 after deductible		$0 after deductible		
Brand Non-Preferred	$115 or 35% (greater of) maximum of $215 after deductible		$0 after deductible		
CanaRx	100% after deductible	Not applicable	100% after deductible	Not applicable	Deductible is applied.

Prescription Drug Benefit

SPECIALTY DRUG LIMITATION LANGUAGE

A Specialty Drug is a drug that targets and treats specific complex conditions or illnesses such as cancer, rheumatoid arthritis, multiple sclerosis, hepatitis C, and HIV/AIDS. Specialty Drugs require patient- specific dosing and careful clinical management. Often these drugs are in the form of injected or infused Medicines. Because specialty drugs require special clinical monitoring, they are typically not dispersed through a traditional retail pharmacy; there-fore some medications have to be dispensed through specialty pharmacies. True Rx consistently reviews pricing for Specialty Drugs to find the best value. Therefore, True Rx reserves the right to change the specialty pharmacies from which Specialty Drugs may be obtained and to negotiate pricing for Specialty Drugs to obtain the most cost- effective solution. If you obtain Specialty Drugs at pharmacies that are not approved by True Rx, you will be responsible for 100% of the cost of those Specialty Drugs and they will not be covered under this Prescription Drug Program. Any amounts that you spend toward Specialty Drugs from non-approved pharmacies will not count toward any applicable deductibles or out-of-pocket maximum limits related to the Prescription Drug Program or the Health Care Plan. You can always request the currently-approved specialty pharmacies by contacting the Customer Service Team at (866) 921-4047.

Specialty drugs will no longer be covered under this plan if the patient qualifies for patient assistance from the drug manufacturer or any other available assistance plan. If the patient does not qualify for assistance, coverage will be available under this plan. TrueRx will provide guidance and instruction for the patient to assist with the qualification process.

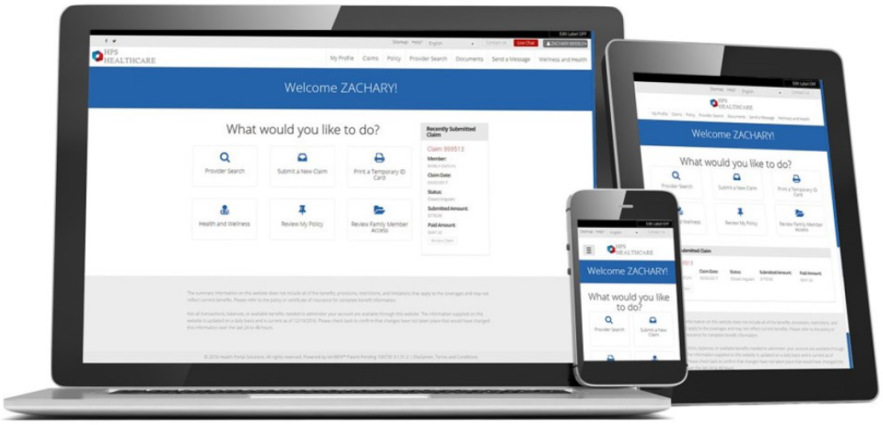
- ✓ If you are prescribed a specialty drug, the Plan requires Plan participants to enroll in an advocacy program administered through True Rx.
- ✓ All Plan participants using specialty drugs are required to meet prior authorization and administrative review criteria.
- ✓ True Rx will help you obtain your specialty drugs by identifying alternative forms of funding. You must enroll in the program and comply with the alternative funding program's eligibility criteria determination process to qualify.
- ✓ If you choose not to enroll in the alternative program, you will be responsible for 100% coinsurance on your specialty drugs.
- ✓ If you are not eligible for an alternate funding program, your case will be submitted to the Plan for benefit consideration under the 1st level appeal process. Should an exception be approved, your out of pocket cost will be adjusted to the Plan's co-insurance and any other Plan limitations will apply.
- ✓ If no alternative funding is found to be available but you are granted an exception on appeal then the Specialty drug copays will apply.

Out-of-Pocket Expense/Deductible

The following amounts do not accrue toward the Out-of-Pocket Expense or Deductible Expense.

- premiums;
- expenses that are not covered under this Prescription Drug Program;
- expenses in excess of the reasonable and customary charges for services or supplies;
- expenses in excess of any maximum benefit list in the Prescription Drug Program;
- penalties;
- expenses reimbursed or covered through assistance programs or discount programs; and
- expenses related to non-preferred brand-name drugs and brand-name drugs when there is a generic equivalent that is medically appropriate.

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:

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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!

Swift MD

Welcome to SwiftMD

Eligible employees and dependents can talk to a doctor 24/7 by phone or videoconference at no cost for co-pays or consult fees!

Some of the Benefits of SwiftMD:

- 24/7 nationwide access to U.S. Board-Certified physicians
- Convenient consults from your home, office, or on the road, usually within 30 minutes
- Doctor makes diagnosis and recommends treatment, and sends prescriptions to your preferred local pharmacy
- Avoid unnecessary visits to the ER and Urgent Care, or long waits for appointments at your doctor's office
- **No co-pays and no cost to you!** Southeast Dubois County School Corporation is paying for your membership!

Getting Started:

- Go to **SwiftMD.com** member login and click "Get Started"
- Enter Group Passcode: SEDUBOIS17, company name, your name, birthdate, email address and other info
- SwiftMD will send an activation email; be sure to log on to complete activation of your membership!

– OR –

- You can use SwiftMD anytime simply by calling toll free **833-SWIFTMD (833-794-3863).** Your membership will be verified, and your appointment scheduled for a callback from a SwiftMD doctor.

SwiftMD Physicians Are:

- U.S.-trained and Board Certified
- Experienced at diagnosing a range of illnesses and injuries, with a minimum of 10 years practicing medicine
- Excellent communicators with great bedside manner!

SwiftMD does not replace your PCP or specialists managing chronic and serious conditions. SwiftMD doctors do not prescribe controlled substances, psychiatric, and certain other medications. For more info review the Exclusionary Criteria at mySwiftMD.com.

Southeast Dubois County School Corporation

GROUP PASSCODE:
SEDUBOIS17

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
- Lyme disease
- Sinusitis
- Sore throat
- Stomach ache and nausea
- Upper respiratory infections
- Urinary tract infections
- Vomiting
- Your individual concerns

Lab Program

Using the Lab Card program is as easy as 1-2-3…
1 – When your physician orders laboratory work for you, show your Lab Card or Healthcare ID card with the Lab Card logo on it and **verbally request** to use the Lab Card Program. Your physician will then collect your specimen and send to Quest Diagnostics under the Lab Card benefit.

2 – Any physician can collect specimens and call Quest Diagnostics Lab Card Client Services at (800) 646-7788 for courier pick-up and supplies. In the event your physician does not participate with the Lab Card Program, simply take your test orders to an approved Lab Card collection site for the draw. Collection site locations can be found by calling Lab Card
Client Services or by going to the website at www.labcard.com.

3 – Your specimens will be processed through the Lab Card program at an approved Quest Diagnostics facility and results sent back to your physician (usually within 24 - 48 hours).

For the most current listing of collection sites available, please go to the website at www.labcard.com. The website also provides you with other information and capabilities:

- Ability to print a temporary Lab Card / order a replacement Lab Card
- Instructions on how to use the Lab Card
- Printable Q&A for physicians
- "Contact my physician" feature to provide information on the Lab Card Program

To receive the benefits of the Lab Card program, you **must present** your Lab Card and **request** the Lab Card program at the time of service. The physician's office and collection sites will need a copy of your Lab Card or Healthcare ID card with the Lab Card logo on it each time you go for services.

Remember – the Lab Card program is completely voluntary and provides you with 100% coverage for all your covered outpatient laboratory testing services. **With the high deductible plan, your benefit will pay after deductible.**

Visit www.labcard.com to find a draw site near you.

Lab Card®
1-800-646-7788
www.LabCard.com

CanaRx

SoutheastDuboisSchoolsCanarx is a voluntary international mail order prescription program that is available to eligible employees, retirees and their dependents of Southeast Dubois County Schools.

Brand name medications, in the original factory-sealed manufacturers packaging, are delivered DIRECT TO YOUR DOOR from certified pharmacies in Canada, the United Kingdom and Australia. YOU PAY NOTHING thanks to the savings CANARX brings to your plan.

Getting started is super easy!

1. Check to see if a medication is offered. Call **1-866-893-6337** and speak with a CANARX representative or view the complete formulary and print enrollment material at **www.SoutheastDuboisSchoolsCanarx.com**.
2. Ask your doctor for a prescription for a 3-month supply, with 3 refills.
3. Submit documentation (completed enrollment form, prescription and a copy of your photo ID).
4. Sit back and relax...medication will be mailed direct to your home within 4 weeks!

- $0 Copay
- 350+ FREE Brand Name Medications
- Easy, convenient refills
- Refills only, no "new to you" meds
- No additional costs

For More Information

1-866-893-6337
www.SoutheastDuboisSchoolsCanarx.com
June 2021

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SoutheastDuboisSchoolsCanarx

Introduction:

SoutheastDuboisSchoolsCanarx is a voluntary prescription drug program that is available to eligible employees, retirees and their dependents of Southeast Dubois County Schools. An expanded list of preventive medications is available to you through this program only. For your convenience, a list of eligible medications is located on the back of this page.

Program Savings:

All member copayments have been **waived** for this program **only**. In addition, by enrolling in this program you will save your health plan substantially on the cost of these medications. It is truly a WIN/WIN for both you and the health plan.

SoutheastDuboisSchoolsCanarx Vs. Current local purchase plan

Annual Cost *No Copays!*		Current Retail Copays		Refills		Annual Savings
$0	Vs.	$40 *(Tier 2)*	x	12	=	$480 / Script
	Vs.	$60 *(Tier 3)*	x	12	=	$720 / Script

Ordering Instructions:

To place your first order please submit: a completed enrollment form; a new prescription for each medication; and a copy of your photo identification*.

**Similar to a number of states in the US, some Canarx pharmacies require a copy of photo ID be provided prior to dispensing the medications. In order to prevent order delays, we encourage patients to include a clear copy of their photo identification with their enrollment form or upload directly to our secure site www.CanarxDocs.com. If not included, a Canarx representative will contact you when required by the pharmacy dispensing your medications.*

Ask your doctor for a prescription for a 3 **month supply** with 3 **refills**. We will call you prior to each renewal to ensure that you have a continuous supply. Please allow 4 weeks for delivery.

Medications must be tried for 30 days before ordering through **SoutheastDuboisSchoolsCanarx.**

RETURN YOUR COMPLETED AND SIGNED ENROLLMENT FORM AND ORIGINAL PRESCRIPTIONS:

BY FAXING TO: 1-866-715-MEDS (6337) **TOLL FREE**

Faxed prescriptions are ONLY accepted if sent directly from the physician's office.

OR

BY MAILING TO: SoutheastDuboisSchoolsCanarx

235 Eugenie St. West
Suite 105D
Windsor, ON, Canada
N8X 2X7

OR

P.O. Box 3009
Windsor, ON, Canada
N8N 2M3

More forms are available:

Additional forms may be obtained by printing them from the website at www.SoutheastDuboisSchoolsCanarx.com or by contacting our Customer Service Representatives toll free at 1-866-893-(MEDS) 6337.

WELCOME TO SoutheastDuboisSchoolsCanarx

Wellness Program

You can earn an annual maximum of $250

SAMPLE – All credits earned will be reimbursed to the employee for expenses incurred; examples of ways to earn credits are:

- **Health Screenings & Health Risk Assessment** $25 (covered employee and covered spouse can earn $25 each)
- **Fitness Program Participation** $25 per month, minimum participation of 10 sessions per month. Includes gym, fitness center, group exercise classes & personal training by a certified instructor.
- **Fitness Activity** (example: Marathon, Half-marathon, Walk) $15 per activity

Self-reported Fitness Activities

- **Participation** $15 per month, minimum of 10 sessions per month. Includes activities such as running, walking, swimming and biking.

  ✓ Track and Report your statistics. Example, how long did you run/walk? How many steps did you take? How many miles did you run/walk?

  ✓ $125 maximum credit per year for self-reported activities.

HOW THE PLAN WORKS!

Credits earned in 2023 will be deposited into your Health Savings Account (HSA) in January 2024 to avoid going over the annual maximum each year.

When an event is completed fill out the Wellness Benefit form, attach proof of participation and submit the information to Dunn & Associates.

NOTE:

✓ Eligible expenses include amounts applied to deductibles, copays and coinsurance through your HSA.

✓ HSA money may accumulate and roll over from year to year if not used!

Fax: (812) 378-9967

-OR-

Email: Lisa Kelley lkelley@dunnbenefit.com

The Wellness Program is not available to Retirees.

Notice Regarding Wellness Program

Southeast Dubois County Schools wellness program is a voluntary program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs to seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a biometric screening, which will include a blood test for glucose, cholesterol and PSA (optional). Employees who choose to participate in the biometric screening will receive Wellness Credits to apply to their out of pocket expenses. Although you are not required to participate in the biometric screening, only employees who do so will receive the premium reduction. Additional incentives of up to $250 may be available for employees who participate in certain health-related activities as described in the Wellness flyer included in the open enrollment guide. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Tracy Troesch 432 E 15th St. Ferdinand, IN 47532 or 812-817-0900. The results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as new options or additional activities to earn more credits. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Southeast Dubois County School may use aggregate information it collects to design a program based on identified health risks in the workplace, Southeast Dubois County School will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers 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 the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are the staff of Jasper Memorial Hospital Wellness Program in order to provide you with services under the wellness program. In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Limited information will be shared with the staff of Dunn and Associates in order to track and apply wellness credits. 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 the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Tracy Troesch 432 E 15th St. Ferdinand, IN 47532 or 812-817-0900.

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 the Southeast Dubois County School, 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 the Southeast Dubois County Schools 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 as of its plan year renewal date of September 1, 2014. 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 for all other enrollees effective on September 1, 2014.

We appreciate the opportunity to serve as your Third Party Administrator and are committed to keeping you informed of any changes that might affect your plan. If you have any additional questions or are unclear how this new law will affect your plan, please do not hesitate to contact us.

Important Notice about Your Prescription Drug Coverage & Medicare

Applies to the Plan A.

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 about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage they offer is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Employer. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage with your employer. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you decide to drop your current coverage your employer, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage. Since you are losing creditable prescription drug coverage under the employer, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
Since the coverage under your employer is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage may or may not be affected. If you drop your current drug plan and enroll in Medicare drug coverage you may enroll back into the benefit plan during the open enrollment period. For More Information about this Notice Or Your Current Prescription Drug Coverage contact your Employer. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through your employer changes. You also may request a copy of this notice at any time. 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 drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of 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.
  If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this 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 2022
Name of Entity/Sender:	Southeast Dubois County School Corporation
Contact--Position/Office:	Tracy Troesch
Address:	432 E 15th St. Ferdinand, IN 47532
Phone Number:	(812) 817-0900

Important Notice about Your Prescription Drug Coverage & Medicare

Applies to Plan B.

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

1. Medicare prescription drug coverage became available in 2007 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Your employer has determined that the prescription drug coverage they offer is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

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

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

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

For more information about your options under Medicare prescription drug coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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 2022
Name of Entity/Sender:	Southeast Dubois County School Corporation
Contact--Position/Office:	Tracy Troesch
Address:	432 E 15th St. Ferdinand, IN 47532
Phone Number:	(812) 817-0900

Women's Health & Cancer Rights Act (WHCRA)

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.

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 Tracy Troesch

.

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	4. Employer Identification Number (EIN)
Southeast Dubois County Schools	35-2030550
5. Employer address	6. Employer phone number
432 E 15th St.	(812) 817-0900

7. City	8. State	9. ZIP code
Ferdinand	Indiana	47532

10. Who can we contact about employee health coverage at this job?	
Tracy Troesch	
11. Phone number (if different from above)	12. Email address
	tracy.troesch@sedubois.k12.in.us

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.

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
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

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*

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

Your Rights

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. Ask us how to do this.
- 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 die.

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.