

Health Plan Benefits – Enrollment Packet

2021

DUNN & Associates

Enrollment forms are due within 30 days of hire.

Make sure your form has been turned in to
Leiah Bainter or Ruthann Fisher in the Administration Office by the Deadline.

Open enrollment for this plan will be
November 16th to November 30th, 2020

Elections will be effective on January 1st.

Greenfield-Central Community School Corporation

ADMINISTRATOR: Dunn and Associates Benefit Administrators, Inc.
Phone: (812) 378-9960
(800) 880-9960
Fax: (812) 378-9967
4550 Middle Road, Suite A – PO Box 2369
Columbus, IN 47202-2369

CONTACTS:

Debi Ayers, Benefit Analyst dayers@dunnbenefit.com
Tammy Shaw, Claims Manager tshaw @dunnbenefit.com

PRE-UTILZATION: Call Clinix at (800) 227-2298 prior to performing the following services to receive maximum benefits payable under the plan:

- Hospital Stays of 18hrs or more - call 7 days prior to admission or 48 hours if an emergency.
- Obstetrical care – call during 1st trimester.
- Outpatient Surgical procedures requiring an operating room or surgery center
- Skilled Nursing Facility
- Hospice Care
- Radiation Therapy
- Home Health Care
- Outpatient Chemo/Dialysis/Infusions
- Durable Medical Equipment
- Therapy (Physical, Occupational, Speech)
- MRI/PET and CT Scans
- Sleep Studies

IDENTIFICATION CARD:
Each employee will receive an ID card. Families will receive two cards. If additional cards are needed for dependents please request them from your Human Resource Department and additional cards will be provided.

SUBMISSION OF CLAIMS:
In most cases, hospitals and doctors directly bill our office. Claim forms will not be necessary in these cases. If you wish to submit the claim yourself, claim forms will be available from Dunn & Associates.

PPO NETWORK:

Your plan will utilize the Encore Health Network. In-network services at an Encore provider will be covered at the in-network rate (see Schedule of Benefits). If you have any questions concerning the status of a provider in the network, please contact Dunn & Associates. Please visit www.encoreconnect.com to help find a provider in the network.

DRUG PROGRAM:

Your drug program will be administered by TrueRx. You will be able to pay a copay after deductible has been met at network pharmacies or via mail order. It will not be necessary to file a claim form with our office. Drug program information is included on your ID card.

Greenfield Central Community Schools
BIN #: 020958
PCN: 07960000
Rx Group Number: TRUE1149
Rx Member Service: 866-921-4047
Pharmacy Helpdesk: 833-202-8783
www.truerx.com

BENEFITS:
A summary of the benefits available is included in this packet. A Summary Plan Description booklet describing all benefits in detail will be supplied to each employee as soon as possible. It will also be available on-line.

We look forward to servicing your account. Please feel free to call our office with your questions or concerns.

Greenfield-Central Community School Corporation

Medical Benefits

The following benefits will be offered to Greenfield-Central Community School Corporation employees and their eligible dependents as of January 1, 2021.

This 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.

COMPREHENSIVE MEDICAL BENEFITS (Employee and Dependents)

BENEFIT DESCRIPTION	CDHP 1		CDHP 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Maximum	Unlimited	Unlimited	Unlimited	Unlimited
	In and Out-of-Network **combine** to satisfy same annual maximum.			
Pre-utilization	See pre-utilization section, A reduction in benefits will apply if pre-utilization requirements not met.			
Covered Expenses	80% after deductible	60% after deductible	80% after deductible	60% after deductible
	Unless otherwise stated under Special Conditions.			
Deductible (per calendar yr) *S = Single and F = Family*	S - $2,500 F - $5,000		S - $1,500 F - $3,000	
	In and Out-of-Network **combine** to satisfy the deductible. Under both plans, family coverage has a non-embedded family deductible. Meaning the family deductible must be met before coinsurance applies. The family deductible may be satisfied by 1 individual or a combination of covered family members.			
Coinsurance Limit (per calendar yr)	S - $1,500 F - $3,000		S - $1,500 F - $3,000	
	In and Out-of-Network **combine** to satisfy the coinsurance limit.			
Total Out-of-Pocket (per calendar yr)	S - $4,000 F - $8,000 An individual covered under Family coverage has an embedded out-of-pocket limit of $6,750.		S - $3,000 F - $6,000	
	In and Out-of-Network **combine** to satisfy the out-of-pocket limit. **CDHP1** has an individual embedded out-of-pocket limit of $6,750 on any one person. **CDHP2** has non-embedded family out-of-pocket limit. Meaning the family out-of-pocket must be met before the plan pays 100%. The family out-of-pocket may be satisfied by a combination of family members.			
Emergency Care (at Hospital/Facility)	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Preventative Care	100% no deductible	60% no deductible	100% no deductible	60% 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.			

The GCCSC Wellness Program allows for the opportunity to receive reduced premiums with either the CDHP 1 or the CDHP 2 plan in the following year by participating the school Wellness Screenings. To qualify for reduced premiums on family coverage with a covered SPOUSE, both the employee and the SPOUSE must complete the Wellness Screening. Dependent children do not need to complete the Wellness Screening regardless of age.

Greenfield-Central Community School Corporation

Prescription Drug Benefits

BENEFIT DESCRIPTION	CDHP 1	CDHP 2
	Employee Pays	Employee Pays
	Deductible must be met before prescription copays apply* **The CDHP plans must follow IRS High Deductible Health Plan HDHP guidelines in order to be used with Health Savings Accounts.** No deductible applies to preventive prescriptions – paid at 100%	
Prescription Drug Benefit		
Retail Program		
(30-day supply)	After Deductible is met	After Deductible is met
Generic Drugs	$10	$10
Brand Preferred	20% Min $30 Max $50	20% Min $30 Max $50
Brand Non-Preferred	40% Min $50 Max $70	40% Min $50 Max $70
Preventative (ACA mandate)	$0	$0
Mail Order		
(90-day supply)		
Generic Drugs	$20	$20
Brand Preferred	20% Min $60 Max $100	20% Min $60 Max $100
Brand Non-Preferred	40% Min $100 Max $140	40% Min $100 Max $140
Preventative (ACA mandate)	$0	$0
Specialty Rx		
(30-day supply)	40% Min $75 Max $150**	40% Min $75 Max $150**
	**Specialty Rx* *Coverage available only if the patient does not qualify for patient assistance program.*	
	Discounts are available through pharmacies participating in the Preferred network. If an 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. Contact your Dunn & Associates or your pharmacy benefit manager for additional information regarding specialty rx.	

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; therefore 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.

As of January 1, 2021 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 and/or penalties
- 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;
- 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.

Employee Medical Benefits Contributions – January 1, 2021

Greenfield-Central CSC Certified Health Insurance Premiums

Plan	Coverage	Monthly Premium	Employee Rate per 24 pays (Without Wellness Screening)	Employee Rate per 24 pays (With Wellness Screening)
CDHP 1	Single	$535.22	$100.95	$90.53
	Family	$1,424.07	$295.37	$274.54
CDHP 2	Single	$728.26	$197.47	$187.05
	Family	$1,964.48	$565.58	$544.74

Greenfield-Central CSC Classified Health Insurance Premiums

Plan	Coverage	Monthly Premium	Employee Rate per 24 pays (Without Wellness Screening)	Employee Rate per 24 pays (With Wellness Screening)
CDHP 1	Single	$535.22	$90.32	$79.90
	Family	$1,424.07	$256.54	$235.70
CDHP 2	Single	$728.26	$186.84	$176.42
	Family	$1,964.48	$526.74	$505.91

Greenfield-Central CSC Classified Single Share Health Insurance Premiums

Plan	Coverage	Monthly Premium	Employee Rate per 20 pays (Without Wellness Screening)	Employee Rate per 20 pays (With Wellness Screening)
CDHP 1	Single	$535.22	$108.38	$95.88
	Family	$1,424.07	$307.85	$282.84
CDHP 2	Single	$728.26	$224.21	$211.70
	Family	$1,964.48	$632.09	$607.09

2021 Dental Rates					
Dental	**Premium**	**Annualized**	**Corporation Contribution**	**Employee Contribution**	**Employee per pay (26)**
Single	$43.26	$519.08	$400.00	$119.08	$4.58
Family	$74.63	$895.56	$400.00	$495.56	$19.06

2021 Dental Rates					
Dental	**Premium**	**Annualized**	**Corporation Contribution**	**Employee Contribution**	**Employee per pay (20)**
Single	$43.26	$519.08	$400.00	$119.08	$5.96
Family	$74.63	$895.56	$400.00	$495.56	$24.78

Vision insurance is no charge to the Employee

GREENFIELD CENTRAL COMMUNITY SCHOOL CORPORATION

2021 WELLNESS BENEFIT

OPTIONS	EARNINGS
Health Screening	*Participate to earn Premium Reduction incentive. Mandatory to be eligible for 2020 employee contribution reduction.*
Health Screening and Health Risk Assessment	**$50**
Health Standards Met 3 out of 5 4 out of 5 5 out of 5	 **$50** **$75** **$100**
Diabetes Prevention Program	**$100** if program completed
Fitness Program Participation. Includes: gym, Fitness center, group exercise classes, personal training by certified instructor. Minimum of 8 X month.	**$25** month Maximum $100 per year
Participate in sanctioned events such as runs, walks, and bikes.	**$15** each Maximum $60 per year
Flu Shot	**$15**
Preventative Screenings appropriate for age/gender such as Physical, Pap test, Mammogram, PSA test, Colonoscopy	**$25** each Maximum $75 per year
Smoking Cessation (Quit Line or Quit Now)	**$40**
Monthly Fitness Challenge or Health Seminar (through Hancock Regional Wellness)	**$20** each Maximum $120 per year

Other events to be announced at a later date.

HOW THE PLAN WORKS!

Credits earned in 2021 by participation in the Wellness program events will be deposited in your HRA or HSA.

This money will be available January 1, 2022 to reimburse you for Out of Pocket expenses. Eligible expenses include deductible, copay, and coinsurance cost for Medical, Dental, and Vision expenses.

NOTE:

- ✓ Expenses must be incurred January 1, 2021 or later to be eligible for HRA/HSA reimbursement.
- ✓ HRA/HSA money may accumulate and roll over from year to year if not used! Credits earned during the year will be available on January 1 of the following year. Maximum credit earned per year is $250 for covered employees or retirees and $250 for covered spouses. Family maximum = $500 per year.
- ✓ If you or your spouse participate in Section 125 Flexible Spending Account, please notify Dunn & Associates.
- ✓ We will coordinate HRA payments with your FSA payments.

Hancock Regional Hospital's Wellness Program will notify Dunn & Associates when an event is completed. Dunn & Associates will track your participation and credit your account on January 1 of each year. If you participate in the HRA account, Dunn will process any eligible claims and reimburse the employee.

If a plan participant is unable to participate in the Health Screenings due to health issues, please contact Dunn & Associates to discuss a reasonable alternative solution.

Greenfield Central Community Schools

Wellness Benefit Claim Form

Part 1

Please type or print clearly

Employee's Name: _____

Address: _____

_____

Telephone #: _____

Part 2

SIGN/DATE

I certify that the expenses for which reimbursement is requested under the Wellness Benefit were incurred by myself or my eligible spouse. I further certify that these expenses are not reimbursable under any other plan, including a plan of another employer that covers me.

_____ _____

Employee Signature Date

Part 3

COMPLETED ACTIVITIES

Attach verification and, if applicable, proof of attendance for any Wellness Plan activity or program event to earn wellness credits.

Description of Eligible Activity or Event	Person Completing the Activity or Event	Date of Completion or Service Date	Total Amount of Credits Earned
			$
			$
			$
			$

TOTAL CREDITS EARNED: $

When an event or activity is completed, fill out the Wellness Benefit Claim form, attach proof of participation and submit the information to Dunn & Associates to receive your HRA credit.

Mail: P O Box 2369 Columbus, IN 47202-2369
Fax: 812-378-9967
Email: dayers@dunnbenefit.com

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:

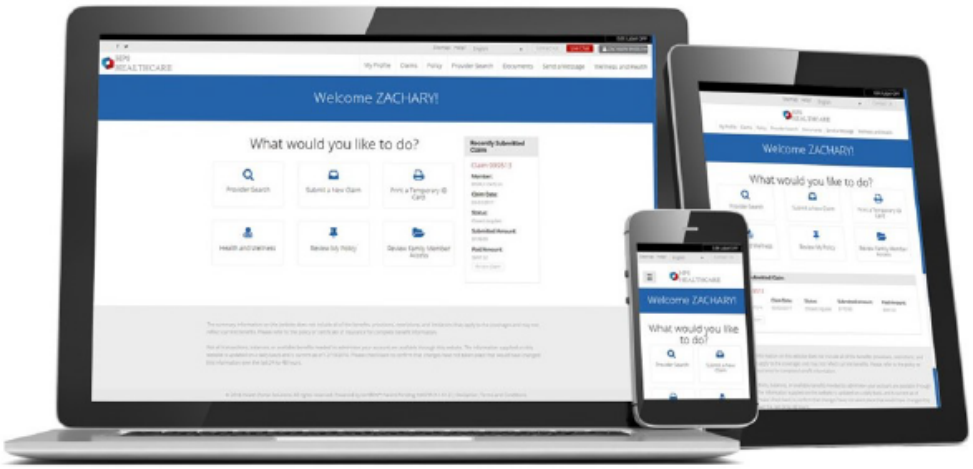
- Ability to print a temporary Lab Card / order a replacement Lab Card
- Instructions on how to use the Lab Card
- Printable Q&A for physicians
- "Contact my physician" feature to provide information on the Lab Card Program

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.

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

NOTE: IF YOU ARE COVERED BY A HIGH DEDUCTIBLE HEALTH PLAN, YOUR DEDUCTIBLE WILL APPLY BEFORE ANY BENEFITS ARE PAID.

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!

Greenfield-Central Community Schools

SwiftMD Telemedicine

Healthcare on Demand

SwiftMD is a telemedicine service that delivers quality health care directly to patients in need. SwiftMD Members enjoy access to high-quality, convenient medical care over the phone or videoconference, 24 hours a day, seven days a week — while saving you money.

Benefits that SwiftMD members enjoy 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!** Your employer is paying for your membership!

Member Testimonials:

- "The doctor that I spoke with was kind and had an excellent bedside manner."
- "This service is amazing and convenient. I love it!"
- "Especially on the occasion you are unable to get in to see your primary physician, SwiftMD is a tremendous service. Prompt service and professional knowledgeable staff that let you know you are in good hands."

To Access your SwiftMD Account:

- When your Membership becomes active on **January 1, 2018**, simply call our Toll-Free Phone Number (1-877-999-7943) when seeking health advice. Your membership will be verified, and then your appointment will be scheduled! Receive a call back within 30 minutes of scheduling your appointment!

YOUR SWIFTMD PROGRAM START DATE:

January 1, 2018

SOME OF THE CONDITIONS WE TREAT:

- Allergies
- Fever & Flu
- Headache
- Insect bites & stings
- Pink Eye
- Prescriptions when appropriate
- Rashes
- Sore Throat
- Upper Respiratory Infections
- Upset Stomach
- Urinary Tract Infections
- Vomiting
- Your individual medical concerns

ONLINE PASSCODE: GRNFLDCTRL

Delta Dental of Indiana

Dental Benefit Highlights for

Greenfield Central Community School Corporation #5684

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%
Implant Repair - implant maintenance, repair, and removal	80%	80%	80%
Major Services			
Major Restorative Services - crowns	50%	50%	50%
Relines and Repairs - to prosthetic appliances	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 – $750 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.

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.

IT'S TIME TO ENROLL IN YOUR VSP VISION BENEFIT!

You and your eyes deserve to be healthy and happy. We can help! See why you should enroll in VSP Vision Care.

LIFE'S A TRIP. ENJOY THE SIGHTS.

VSP Vision care for life

SAVINGS YOU EXPECT.
VSP® members save on eyewear and eye care with a VSP network doctor. You'll also have access to Exclusive Member Extras, like savings and special offers, that can save you more than $3,000.

CHOICES YOU DESERVE.
With an average of five VSP network doctors within six miles of you, it is easy to find a nearby in-network doctor to maximize your vision coverage. Visit **vsp.com** or call **800.877.7195** to find a Premier Program location and get the most out of your benefits.

STYLES YOU'LL LOVE.
You'll find hundreds of frame options for you and your family. Get an extra $20 to spend on featured frame brands like bebe, CALVIN KLEIN, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more. Plus, save up to 40% off on lens enhancements!*

ENROLL BY 11/30/2020
CONTACT YOUR EMPLOYER FOR ENROLLMENT DETAILS.

Visit seemuchmore.com for more information.

Your VSP Vision Benefits

Welcome to VSP® Vision Care. We'll help keep you and your eyes healthy through personalized care from a doctor you can trust.

Your eyes say a lot about you and can even tell your VSP doctor about you. During your WellVision Exam®, your VSP doctor will look for vision problems and signs of health conditions too.

Getting started is a breeze.

- **Find the right VSP doctor for you.** You'll find plenty to choose from at **vsp.com** or by calling **800.877.7195**.
- **Already have a VSP doctor?** At your appointment, tell them you're a VSP member.
- **Check out your coverage and savings.** Visit **vsp.com** to see your benefits anytime and check out how much you saved with VSP after your appointment.

That's it! We'll handle the rest—no ID card necessary or claim forms to complete.

Visit the Eyecare Discovery Center® at **vsp.com** for eye health articles, videos, and interactive games.

Keep your eyes healthy and your vision clear with VSP.

Contact VSP | **vsp.com** **800.877.7195**

VSP® Vision care for life

JOB#1750CM 5/09

Greenfield-Central Community School and VSP provide you an affordable eyecare plan.

Your Coverage from a VSP Doctor

WellVision Exam® focuses on your eye health and overall wellness ..... ***every 24 months***

$5.00 copay ***every 24 months***

Prescription Glasses

$10.00 copay ***every 24 months***

Lenses ..... ***every 24 months***

- *Single vision, lined bifocal, lined trifocal, photochromic and tinted lenses.*
- *Polycarbonate lenses for dependent children.*

Frame ..... ***every 24 months***

- *$120.00 allowance for frame of your choice*
- *20% off the amount over your allowance.*

~OR~

Contact Lens Care ..... ***every 24 months***

$120.00 allowance for contacts and the contact lens exam (fitting and evaluation).

New and current soft contact lens wearers may be eligible for a special program that includes an initial contact lens evaluation and initial supply of lenses.

Vision Therapy

This enhancement allows you to obtain a supplemental evaluation and treatment plan to correct or improve severe visual problems associated with sensory and/or muscular deficiencies of the eye. Benefit criteria must be met. Contact your VSP doctor for more information.

Extra Discounts and Savings

Glasses and Sunglasses

- *Average 35 - 40% savings on all non-covered lens options*
- *30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam*

Contacts

- *15% off cost of contact lens exam (fitting and evaluation)*

Laser Vision Correction

- *Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.*
- *After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor*

If you see a non-VSP provider, you'll receive a lesser benefit. Before seeing a non-VSP provider, call us at 800.877.7195 for more details.

Out-of-Network Reimbursement Amounts:

Exam	*Up to $40.00*
Single vision lenses	*Up to $30.00*
Lined bifocal lenses	*Up to $45.00*
Lined trifocal lenses	*Up to $60.00*
Frame	*Up to $45.00*
Contacts	*Up to $100.00*

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

Patient Protection and Affordable Care Act 2021

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

(both plans)

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 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.

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 & Your 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:	Greenfield-Central Community School Corporation
Contact--Position/Office:	RuthAnn Fischer or Leiah Bainter
Address:	110 W North St. Greenfield, IN 46140
Phone Number:	317-462-4434

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

Notice Regarding Wellness Program

Greenfield-Central Community School Corporation (GCCSC) 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 screenings will receive an incentive of reduced premiums for employee only and family coverage. Although you are not required to participate in the biometric screening, only employees who do so will receive the premium reduction. 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 **Leiah Bainter or Ruthann Fisher at the Greenfield-Central Community School Corporation, 110 W North St, Greenfield, IN 46140 or 317-462-4434.** 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 **GCCSC** may use aggregate information it collects to design a program based on identified health risks in the workplace, **GCCSC** 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 **Hancock Regional Hospital** 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 **Leiah Bainter or Ruthann Fisher at the Greenfield-Central Community School Corporation, 110 W North St, Greenfield, IN 46140 or 317-462-4434.**

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 Leiah Bainter or Ruthann Fisher.

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)
Greenfield-Central Community School Corporation	35-1100181
5. Employer address 110 W North St.	6. Employer phone number (317) 462-4434

7. City	8. State	9. ZIP code
Greenfield	IN	46140

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)	12. Email address
	lbainter@gcsc.k12.in.us or rfisher@gcsc.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.

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.htm*