DUNN & Associates
Benefit ▪ Administrators ▪ Inc.

Enrollment Packet

October 1, 2017

PATOKA LAKE
REGIONAL WATER & SEWER DISTRICT

Patoka Lake Regional Water & Sewer District

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

CONTACT S:

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Section 125 Health Reimbursement/Dependent Care Contacts:

Susan Schindel, Flexible Benefit Analyst	Susan.Schindel@dunnbenefit.com
Barb Mahoney, Finance Manager	Barb.Mahoney@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 18 hrs or more
- Obstetrical Care (*call during 1st trimester)*
- Outpatient Surgical Procedures requiring an operating room or surgery center
- Outpatient Chemotherapy/Dialysis
- Skilled Nursing Facility
- Radiation Therapy
- Home Health Care
- Durable Medical Equipment
- PET Scans/MRI's/CT Scans

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 Patoka Valley Health Care Cooperative/Encircle/Encore Health Network. In-network services at a PVHCC/Encircle/Encore provider will be covered at 80% after deductible. For claims outside of the state of Indiana, your plan will utilize the First Health Network and services will be covered at 80% after deductible. Out-of-network claims will be covered at 50% after deductible.

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 True Rx. It will not be necessary to file a claim form with our office. Drug program information is included on your ID card.
BIN #: 014955 PCN #: PDMI Group #: 99991709
Rx Member Services: 866.921.4047
Pharmacy Helpdesk: 866.949.4405
Website: 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.

Schedule of Benefits October 1, 2017

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.

COMPREHENSIVE MEDICAL BENEFITS (Employee and Dependents)

	PPO Plan		
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Annual Maximum (per individual)	Unlimited	same maximum for in-network applies to out-of-network (combined maximum)	Some covered expenses have separate annual and/or lifetime maximums as stated under Special Conditions.
Deductible (per calendar yr) Individual Family	 $0 $0	 $0 $0	In- and out-of-network deductible accumulate separately. Deductible applies to all covered expenses unless otherwise stated under Special Conditions.
Covered Expenses (plan pays)	80% after deductible	50% after deductible	Unless otherwise stated under the Schedule of Benefits and /or Special Conditions.
Coinsurance Limit Individual Family	 $2,000 $4,000	 $2,000 $4,000	Per calendar year include Rx. In- and out-of-network coinsurance limits accumulate separately. 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.
Total Out of Pocket Individual Family	 $2,000 $4,000	 $2,000 $4,000	Per calendar year and includes deductible and any applicable copays. In- and out-of-network coinsurance limits accumulate separately.

SPECIAL CONDITIONS			
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Physician Office Visit	80% after deductible	50% after deductible	
Emergency Care	$50 copay then 100% after deductible		Copay is waived if admitted.
Emergency Transportation	80% after deductible	50% after deductible	
Urgent Care	80% after deductible	50% after deductible	
Voluntary Second Surgical Opinion	80% after deductible	50% after deductible	
Outpatient Surgery	80% after deductible	50% after deductible	Includes facility and all professional fees.
Imaging Tests (CT/PET/MRI)	80% after deductible	50% after deductible	
Hospital Room & Board Intensive Care	80% after deductible 80% after deductible	50% after deductible 50% after deductible	Limited to semi-private room rate. Limited to 4 times semi-private room rate
Mental Health/Substance Abuse Care	80% after deductible	50% after deductible	
Home Health Care	80% after deductible	50% after deductible	Annual individual maximum of 40 visits.
Hospice Care	80% after deductible	50% after deductible	
Extended Care/Skilled Nursing Facility	80% after deductible	50% after deductible	Annual individual maximum of 31 days.
Preventative Health Care	100% no deductible	50% after deductible	
Physiotherapy Outpatient Care	80% after deductible	50% after deductible	
Chiropractic Care	80% after deductible	50% after deductible	Limited to an annual individual maximum of 12 visits. Acupuncture is not covered.
TMJ	80% after deductible	50% after deductible	

Laboratory Expenses Designated Facility All Other Facilities	 100% no deductible 80% after deductible	 Not applicable 50% after deductible	For more information regarding designated facilities, please contact Dunn & Associates.
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Organ Transplants	100% after deductible at Designated Facility 90% of the first $100,000 after deductible at Non-Designated Facility	50% after deductible	Primary coverage with the fully insured organ transplant policy.
Dialysis	80% after deductible	50% after deductible	Limited to 50 treatments per episode of care. Treatment will be considered a separate episode of care if more than 180 days have lapsed since the last treatment.
Prescription Drug Benefit <u>Retail Program</u> (34-day supply) Generic Drugs Brand Name Non Brand Name <u>Mail Order</u> (90-day supply) Generic Drugs Brand Name Non Brand Name Specialty Drugs	 <u>Employee Pays</u> $10.00 20% (maximum $25) 40% (maximum $50) $25.00 20% (maximum $50) 40% (maximum $100) 50% (maximum $150)		

* 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.

Certain brand name medications will be restricted until a therapeutically-equivalent generic has been utilized for a three (3) month period. Current classes of medications include stomach acid reducers, cholesterol, blood pressure, osteoporosis, nasal steroids and certain anti-depressants. Additional classes include sedatives, migraine, irritable bowel and acne medications. These categories and the medications included within are subject to change.

Please contact **True Rx** at **(866) 921-4047** for a complete list of medications or with any questions and/or concerns.

Your Vision Benefits Summary

Get access to the best in eye care and eyewear with PATOKA LAKE REGIONAL WATER & SEWER DISTRICT and VSP® Vision Care.

Using your VSP benefit is easy.

- **Create an account at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** The decision is yours to make—choose a VSP network doctor or any out-of-network provider. Visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Best Eye Care

You'll get the highest level of care, including a WellVision Exam®– the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.[1] Visit **vsp.com** to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.[2] Prefer to shop online? Check out all of the brands at **eyeconic.com®**, VSP's preferred online eyewear store.

Plan Information

VSP Coverage Effective Date: 01/01/2018
VSP Provider Network: VSP Choice

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$10
Prescription Glasses		$30
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • Every other calendar year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every other calendar year	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements • Every other calendar year	$55 $95 - $105 $150 - $175
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every other calendar year	Up to $60
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.	
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam	
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit **vsp.com** for plan details.

Exam	up to $45	Lined Trifocal Lenses	up to $65
Frame	up to $70	Progressive Lenses	up to $50
Single Vision Lenses	up to $30	Contacts	up to $105
Lined Bifocal Lenses	up to $50		

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Visit vsp.com or call 800.877.7195 for more details on your vision coverage and exclusive savings and promotions for VSP members.

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

Quest Diagnostics®

Lab Card®
1-800-646-7788
www.LabCard.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. Remember – the Lab Card program is completely voluntary and provides you with 100% coverage for all your covered outpatient laboratory testing services.

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

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.

Patient Protection and Affordable Care Act 2017

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

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

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

Grandfathered Plan Status
This plan is considered to be a "Non-Grandfathered Plan" under the PPACA. Being a non-grandfathered plan means that the Plan includes certain consumer protections of the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a non-grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Dunn and Associates Benefit Administrators at 812-378-9960 or 800-880-9960. The Plan participant may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa.

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

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

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

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

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

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

Important Noticed about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage. Medicare prescription drug coverage became available in 2007 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Your employer has determined that the prescription drug coverage they offer is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage. Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from 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 & 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:	October 2017
Name of Entity/Sender:	Patoka Lake Regional Water & Sewer District
Contact--Position/Office:	Luke Woolems
Address:	2647 N St Rd 545 Dubois, IN 47527
Phone Number:	812-678-8307

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approv
OMB No. 1210-01
(expires 5-31-202

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 Luke Woolems.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Patoka Lake Regional Water & Sewer District	35-2035870
5. Employer address	**6. Employer phone number**
2647 N St Rd 545	812-678-8307

7. City	8. State	9. ZIP code
Dubois	IN	47527

10. Who can we contact about employee health coverage at this job?	
Luke Woolems	
11. Phone number (if different from above)	**12. Email address**
	luke@plrws.net

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 see eligibility section of your Summary Plan Description booklet. If you do not have an SPD you can find one at www.dunnbenefit.com or request a copy from your employer.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Please see eligibility section of your Summary Plan Description booklet. If you do not have an SPD you can find one at www.dunnbenefit.com or request a copy 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.html*

Patoka Lake Regional Water & Sewer District

SwiftMD Telemedicine

Online passcode: PLRWSD17

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, 2017, 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, 2017

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

Dental Benefits

HRI Dental will administer the dental plan effective January 1, 2018
Dental Benefits will be voluntary and need to be elected by the employee.

GROUP #08012017PATO

Dental Health Options by Health Resources, Inc (HRI) has been "Insuring Smiles" and providing group dental benefits to a growing membership since 1986. Providing savings, flexibility and responsiveness to our customer are key elements to our service culture.

Protecting employees and providing affordable premium rates are top priority. We provide robust network savings – averaging 15%-30% on covered dental services from over 50,000 network dentists nationwide!

Network dentists also file all claim forms and cannot balance bill members.
Out-of-network dentists are under no contractual obligation to the Plan or member to accept customary fees or file claims. Plan membership benefits include:

- No claim forms
- No missing tooth exclusions
- No waiting periods
- Large, nationwide network of dentists
- No pre-existing conditions
- Comprehensive dental benefits

HRI is the dental benefit of choice for over 50 Cities in Kentucky and Indiana alone!

Benefits of Dental Health Options

- No Waiting Periods - immediate benefits for basic, major services.
- No Pre-existing Condition Clauses - No missing tooth exclusion.
- NETWORK - We offer your area's strongest dental network along with over 380,000 network dental locations Nationwide. To search our network directory, simply visit InsuringSmiles.com.
- In and Out of network option allowing members to receive services from any dentists. Members utilizing a network dentist receive significant savings and no balance billing

Deductible	$0 Single/Family
Preventative Care	paid at 100%
Plan Year Individual Maximum	$1,000
Orthotic Lifetime Maximum (child only)	$1,500

Any questions regarding your new dental plan, please contact HRI Dental

Insuring Smiles.com
PO Box 659
Evansville, IN 47704
Telephone: 800-727-1444
Fax: 812-401-5448

dental health OPTIONS® by Health Resources, Inc.

Product Summary Guide for Patoka Lake Regional Water and Sewer District

Plan: 3

To find a dentist visit:
InsuringSmiles.com/FindADentist

Plan Features:
Network Option: In and Out of Network
Plan Year: January

PLAN ANNUAL MAXIMUM BENEFIT: $1,000

DENTAL SERVICES COVERED AT 100% *

PREVENTIVE SERVICES
Routine teeth cleaning
Fluoride applications
Sealants (permanent molar teeth only)
Space maintainers (not orthodontic retainers)

DIAGNOSTIC SERVICES
Evaluations (exams)
- Periodic, limited, comprehensive, periodontal

Radiographs (x-rays)
- Complete series
- Panoramic films
- Bitewings

Other procedures
- Pulp vitality tests
- Diagnostic casts

DENTAL SERVICES COVERED AT 80% *

RESTORATIVE
Silver fillings
- Primary teeth / Permanent teeth

White fillings
- Anterior teeth / Posterior teeth

ENDODONTICS
Root canal therapy
- Anteriors / Premolars / Molars
- Retreatment

ORAL SURGERY
Extractions
- Routine removals or exposed roots

DENTAL SERVICES COVERED AT 50% *

RESTORATIVE
Inlay/Onlay (metallic & porcelain)
Crowns
- Porcelain/ceramic
- Full cast/¾ cast
- Prefabricated stainless steel
- Recementation

Other restorative services
- Protective restoration
- Core buildup including pins
- Pin retention
- Post & core
- Labial veneers (anterior teeth)

ENDODONTICS
Vital pulpotomy (primary teeth only)
Pulp therapy (primary teeth only)
Apexification
Apicoectomy
Root amputation

PERIODONTICS
Gingivectomy, per quadrant
Crown lengthening
Osseous surgery
Soft tissue grafts
Distal or proximal wedge
Scaling and root planing
Full mouth debridement
Periodontal maintenance

PROSTHODONTICS
Removable
- Complete/Immediate dentures
- Partial dentures
  - All acrylic
  - Metal framework, acrylic saddles
- Repairs/Reline
- Tissue conditioning

Fixed bridgework
- Bridge pontics & retainers
- Resin bonded (Maryland) bridge
- Recementation
- Post & core

IMPLANT SUPPORTED PROSTHETICS (RESTORATIONS)
Removable dentures, abutment supported
Crowns, abutment supported
- Porcelain/ceramic/cast metal

Fixed bridgework, abutment supported
- Porcelain/ceramic/cast metal

ORAL SURGERY
Extractions
- Surgical removals
- Impactions

Natural tooth reimplantation
Surgical exposure or unerupted tooth
Biopsy, soft tissue
Incision and drainage of abscess
Frenectomy
Excise hyperplastic tissue
Alveoloplasty (smoothing of bone)

ADJUNCTIVE
Palliative emergency treatment
Anesthesia
- General anesthesia
- Intravenous sedation
- Analgesia (nitrous oxide)

Athletic mouth guards
Bleaching (anterior teeth, supervised in office)

Your Employer will sponsor your plan and select your individual annual maximum dollar level, of which the benefit accumulation period is the Plan year. Your employer will also collect your portion of the premiums via payroll deduction and define eligibility requirements. You may not add, drop or change coverage during each contract period unless a qualifying event occurs. All plans are issued subject to certain exclusions, limitations and restrictions such as frequency and age limitations. These exclusions, limitations and restrictions, and a listing of all covered services by ADA code, are described in the Employer group contract and your Member handbook, which are available on our website or by calling HRI at 800-727-1444.

* Applicable to covered services obtained from a network dentist. Non-participating dentists may balance bill.

DUNN & Associates
Benefit ▪ Administrators ▪ Inc.

You have internet access to:

- ✓ BENEFITS INFORMATION
- ✓ PROVIDER NETWORK INFORMATION
- ✓ ELIGIBILITY INFORMATION
- ✓ CLAIMS DATA
- ✓ MESSAGE CENTER

Accessing Dunn Online:

Easy as…

1. visit our website www.dunnbenefit.com
2. click on the "benefits portal" link
3. register as a new user; once activated you will receive a confirmation email and be able to have benefits information at the tips of your fingers.