

Bartholomew County Public Library

2026 Employee Benefits Guide



**Bartholomew
County
Public Library**

 Johnson-Witkemper, Inc.
Insurance Services

DUNN
 Associates
Benefit • Administrators • Inc.

General Information

You play an imperative part in the plans victory. That's why every attempt has been made to make available the best benefits program that compensates you for the hard work you put forth. Benefits are an important part of your total compensation package. This guide provides information to help you better understand your health plan and benefits. During open enrollment period December 1 to December 5, 2026, you have the chance to review your needs, review the benefits available to you and make selections that are most valuable to you. Open enrollment is your chance to make changes to your benefit enrollments. The benefits you choose during this time will be effective **January 1, 2026**.

Who is Eligible?

You're eligible for benefits if you meet the following requirements:

Employees – All full-time employees and their eligible dependents can participate in this plan. Eligible dependents include:

- Spouse
- Natural, step or adopted child(ren) under age 26
- Child(ren) undergoing legal guardianship
- Child(ren) under a qualified medical child support order
- Disabled child(ren) under age 26

NEW 2026 - Working Spouse Rule - If the spouse of the Employee is employed and eligible for coverage under their own employer, benefits under this Plan will not provide coverage for this spouse. The Working Spouse Rule does not apply when both husband and wife are employees of this Employer. However, no person may be both an employee and a dependent of this Plan. This rule applies to medical, dental and vision coverage.

When to Enroll?

Open enrollment will begin December 1, 2025, and any changes will need to be complete by the end of day December 5, 2025.

You must enroll during the annual Open Enrollment period. If you miss open enrollment, you must wait until next year's Open Enrollment period unless you have a qualifying life event. If you experience a life event change, you will need to request to change your benefits within 30 calendar days of the event and provide documentation to Human Resources. **If you are not making any benefit election changes, you do not need to do anything. Unless you cover a spouse and/or children, please fill out the required forms.**

Waiting Period: 1st of the month following hire date.

How to Make Changes?

A life event change (qualifying event) is a personal change in status which may allow you to change your benefit elections.

Examples of qualifying events include:

- Marital Status Change: Marriage, Divorce, Legal Separation
- Dependent Status Change: Birth, Death, Adoption
- Change in Employment: Full-time to Part-Time or vice versa

If after reading the information in this guide you have any additional questions, please contact Dunn & Associates or your Employee Resource Administrator.

Dunn Online:

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

Submission of Claims:

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

Identification Card:

Each employee enrolling for the first time will receive an ID card. Families will receive two cards. If additional cards are needed for dependents, please register online. Using the benefit portal allows you to print your ID card and request a card.

Contact Information

Employer	Bartholomew County Public Library Michelle Williams Joe Joyner	(812) 379-1252	mwilliams@mybcpl.org jjoyner@mybcpl.org
Agent/Broker/Consultant	Johnson-Witkemper, Inc. Brian Walsch	(812) 372-0841	bwalsch@jwinsurance.com
Medical & Dental Benefits	Dunn & Associates/Claims Penny Wolter	(812) 378-9960 (800) 880-9960	pwolter@dunnbenefit.com claimsdept@dunnbenefit.com
Eligibility	Dunn & Associates/Eligibility	(812) 378-9960 (800) 880-9960	eligibility@dunnbenefit.com
Section 125	Dunn & Associates/Finance	(812) 378-9960 (800) 880-9960	financedept@dunnbenefit.com
Pharmacy Benefit Manager	TrueRx	(866) 921-4047	www.truerx.com RxBin 020958 RxPCN 0796000 RxGrp TRUE1252
Precertification	Clinix Healthcare	(800) 227-2298	www.clinix.com
PPO	Encore Health Network	(888) 574-8180	www.encorehealthnetwork.com
Telemedicine	Revive Health (urgent care or mental health)	(833) 794-3863	www.revive.health Passcode: BRTMWCTY17
International Prescription Drug Mail order Program	CanaRx	(866) 893-6337	www.canarx.com/plan/?planid=BCPL
Life Products	OneAmerica	(800) 553-5318	www.oneamerica.com

Contributions

Employee Cost per Pay (24-pays)

Medical Contributions	Plan A (\$500 Deductible)	Plan B (\$4,000 Deductible)
Employee	\$30.00	\$7.50
Employee plus Child(ren)	\$180.00	\$75.00
Employee plus Spouse	\$250.00	\$90.00
Family	\$350.00	\$150.00

OneAmericaSM
Financial

Life Products		
Life	No cost to employee	
Accidental Death & Dismemberment (AD&D)	No cost to employee	
Short Term Disability (STD)	No cost to employee	

Life Products

Bartholomew County Public Library provides Basic Life/AD&D and Short-Term Disability coverage to all eligible employees at no cost to the employee.

See policy/certificate for more details, this is a summary for informational purposes.



Life Benefits		
Employee Only – Basic Life Benefit	\$50,000	Policy G 00619343-0000-00
Employee Only – Accidental Death & Dismemberment Benefit (AD&D)	\$50,000	
<i>See policy for age reduction schedule.</i>		
Short-Term Disability		
Weekly Payment Benefit	60% of basic weekly salary	
Maximum Period of Payment	26 weeks	
Waiting Period for Illness/Injury	7 calendar days	
STD commences after all sick leave and vacation days have been exhausted.		

Benefit Summary – Plan A

If there is a conflict in terms of benefits between the benefit summary and the Summary Plan Description booklet, the benefits described in the SPD will supersede in determining benefits paid. For a copy of your most recent SPD and any applicable amendments you can request from your Employer, or you can visit www.dunnbenefit.com. See SPD for more details, this summary is for informational purposes.

NEW BENEFITS FOR 1/1/2026 – PLEASE REVIEW CAREFULLY

Benefit	In-Network	Out-of-Network
Annual Deductible - Individual / Family	\$500/\$1,000	\$1,000/\$2,000
Annual Medical Coinsurance - Individual / Family	\$2,000/\$4,000	\$4,000/\$8,000
Annual Rx Coinsurance – Individual/Family	\$2,500/\$5,000	\$2,500/\$5,000
Out-of-Pocket (Includes Deductible) – Individual/Family	\$5,000/\$10,000	\$7,500/\$15,000
Preventive Care Services	100% no deductible	50% after deductible
Office Visit (Primary Care or Specialist)	80% after deductible	50% after deductible
Urgent Care	80% after deductible	50% after deductible
Emergency Room	\$250 copay then 80% after deductible	\$250 copay then 80% after deductible
Inpatient Services	80% after deductible	50% after deductible
Outpatient Services	80% after deductible	50% after deductible
Therapy (Occupational, Physical, Speech)	80% after deductible	50% after deductible
Laboratory Services – Designated Facility All other Facilities	100% no deductible 80% after deductible	50% after deductible

Rx Benefit	Retail (30-day supply)	Retail/Mail Order (90-day supply)
Generic	\$5.00	\$10.00
Brand/Preferred	30%	30%
Non-Brand/Preferred	50%	50%
Specialty	Please contact the pharmacy benefit manager for more information and assistance with specialty drugs.	

Benefit Summary – Plan B

If there is a conflict in terms of benefits between the benefit summary and the Summary Plan Description booklet, the benefits described in the SPD will supersede in determining benefits paid. For a copy of your most recent SPD and any applicable amendments you can request from your Employer, or you can visit www.dunnbenefit.com. See SPD for more details, this summary is for informational purposes.

NEW BENEFITS FOR 1/1/2026 – PLEASE REVIEW CAREFULLY

Benefit	In-Network	Out-of-Network
Annual Deductible - Individual / Family	\$4,000/\$6,000 <i>Embedded</i>	\$8,000/\$12,000 <i>Embedded</i>
Annual Medical Coinsurance - Individual / Family	\$0/\$0	\$2,000/\$4,000
Annual Rx Coinsurance – Individual/Family	\$0/\$0	\$0/\$0
Out-of-Pocket (Includes Deductible) – Individual/Family	\$4,000/\$6,000	\$10,000/\$16,000
Preventive Care Services	100% no deductible	50% after deductible
Office Visit (Primary Care or Specialist)	100% after deductible	50% after deductible
Urgent Care	100% after deductible	50% after deductible
Emergency Room	100% after deductible	100% after deductible
Inpatient Services	100% after deductible	50% after deductible
Outpatient Services	100% after deductible	50% after deductible
Therapy (Occupational, Physical, Speech)	100% after deductible	50% after deductible
Laboratory Services - Designated Facility All other Facilities	100% no deductible 100% after deductible	50% after deductible

Rx Benefit	Retail (30-day supply)	Retail/Mail Order (90-day supply)
Generic	100% after deductible	100% after deductible
Brand	100% after deductible	100% after deductible
Non-Brand	100% after deductible	100% after deductible
Specialty	Please contact the pharmacy benefit manager for more information and assistance with specialty drugs.	

Dental Summary

If there is a conflict in terms of benefits between the benefit summary and the Summary Plan Description booklet the benefits described in the SPD will supersede in determining benefits paid. For a copy of your most recent SPD and any applicable amendments you can request from your Employer, or you can visit www.dunnbenefit.com. See SPD for more details, this summary is for informational purposes.

Dental Benefits	
Annual Deductible	\$50 per individual calendar year – maximum of \$150 per family
Annual Benefit Maximum (per insured person)	\$2,000 (does not apply to orthodontics) <i>*new maximum for 2026</i>
Preventive	100% no deductible
Basic Restorative	80% after deductible
Major Restorative	80% after deductible.
Orthodontia	50% after deductible – limited to a lifetime individual maximum of \$500. Coverage is further limited to dependent children only.

Vision Summary

If there is a conflict in terms of benefits between the benefit summary and the Summary Plan Description booklet, the benefits described in the SPD will supersede in determining benefits paid. Visit www.vsp.com for more details, this summary is for informational purposes.

Vision Benefits	
Annual Maximum	\$750 per individual <i>*new maximum for 2026</i>
Covered Expenses	100% no deductible

Preventative Care

What is preventative care?

Preventive care focuses on maintaining your health and establishing your health status. This may include immunizations, vaccines, physical evaluations, lab work, x-rays and medically appropriate health screenings. During your preventive visit, your doctor will determine what tests or screenings are appropriate for you based on many factors such as your age, gender, overall health status, personal health history and your current symptoms or chronic health concerns. Preventative Care is routine health care that helps you stay on top of your health and catch anything before it becomes an issue.

Most Health plans cover eligible preventative care at \$0 out of pocket.

Recommended Screenings

Visit <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>; to see a list of recommended screenings, by age, or gender, etc...

Some examples are:

- **Annual Physical Exam** (typically with your Primary Care Physician) including BMI, Heart rate check, Blood Pressure test, regular lab work (cholesterol, glucose, etc...) Ask your physician which labs are considered preventative, and which are considered diagnostic (you may have to pay out of pocket for diagnostic testing).
- **Vaccines** – as recommended based on your age and other factors.
- **Flu Shots**
- **Well Baby/Well Childcare**
- **Recommended Cancer Screenings:**
 - Breast
 - Colon
 - Prostate
 - Lung
 - Cervical
- **Pre-Diabetes Screening**
- **Osteoporosis Screening**

Preventative vs. Diagnostic

Prevention aims to stop a problem before it starts. Preventive care can help you avoid potentially serious health conditions and/or obtain early diagnosis and treatment.

Diagnostic is addressing a problem that has already begun.

Lab Program

Approved draw sites:

Prompt Med - 2502 25TH St. Columbus, IN 47201
(812) 372-8883
Monday to Friday 7AM TO 7PM
Saturday & Sunday 7AMm TO 5PM

Other available lab draw sites:



- www.questdiagnostics.com (*see next page*)



- www.alvernolabs.com
123 2nd St. Columbus, In 47201
(800) 937-5521
Monday to Friday 8AM TO 4PM



- www.labcorp.com

QuestSelect™ Plus lab benefit



Control the cost of your healthcare

QuestSelect™ Plus is a value-added health benefit that can help save you money on outpatient laboratory testing. Show your healthcare provider your QuestSelect card to obtain outpatient testing at a reduced out-of-pocket cost.

For a current listing of collection sites visit QuestSelect.com. On the website you can also:

- Print a QuestSelect card
- Read instructions on how to use your QuestSelect benefit
- Find resources you can share with your healthcare provider

To receive the benefits of the QuestSelect Plus program, you must present your QuestSelect card or healthcare ID card with the QuestSelect logo on it at the time of each service, and request your provider send your laboratory testing order to Quest Diagnostics.

The QuestSelect Plus laboratory benefit covers routine outpatient testing. It does NOT cover:

- Testing ordered during hospitalization
- Lab work needed on an emergency basis
- Testing done at another laboratory
- Time-sensitive esoteric testing such as fertility testing, bone marrow studies, and spinal fluid tests

The QuestSelect program is completely voluntary and provides you with significant savings for your covered outpatient laboratory testing. If you and/or your healthcare provider choose to send testing to any laboratory other than Quest Diagnostics, the QuestSelect benefit will not apply.

Saving with QuestSelect™ is simple

1. At your appointment, show your QuestSelect card and ask for your lab work to be sent to Quest.
2. If the office doesn't use Quest for testing, you can ask your provider to call the QuestSelect Lab Line to request a pickup. Or you can ask your provider for a written order to have your lab work collected at an approved Quest Patient Service Center (PSC) location.
3. The sample is collected at the healthcare provider's office or PSC and is sent to Quest Diagnostics for processing.
4. Testing is completed by Quest and results are sent to your provider. You can also access your results through MyQuest™ online.

For more information about your QuestSelect Plus laboratory benefit, visit QuestSelect.com or call 1.800.646.7788 today.

Frequently asked questions

Q. What is QuestSelect?

A - QuestSelect™ is a voluntary program that allows you to obtain outpatient laboratory testing* at low or no cost to you. When your doctor orders lab testing, you can reduce or eliminate co-pays and/or deductibles by showing your QuestSelect™ card and asking to use your QuestSelect™ benefit. The testing must be covered and approved by your health benefit plan and your physician or phlebotomist must indicate that you have QuestSelect™ coverage on a Quest Diagnostics requisition which accompanies your specimens to Quest Diagnostics.

Q. Is use of QuestSelect mandatory?

A - No. This is a voluntary, member-driven program. However, if you choose not to use QuestSelect™, your normal benefits will apply.

Q. Does QuestSelect replace current healthcare benefits?

A - No. It simply provides you the option to receive covered outpatient laboratory testing at low or no out-of-pocket cost to you* when you present your QuestSelect™ card and ask to use QuestSelect™.

Q. Who pays for the laboratory testing when I use QuestSelect?

A - When you use QuestSelect™, your health benefit plan pays some or all of the cost of covered outpatient lab tests - which means deep discounts of up to 100% for you.

Q. What tests are covered under QuestSelect?

A - The program covers diagnostic outpatient laboratory testing provided the tests have been ordered by your physician, are covered and approved by your health benefit plan and you have requested to use QuestSelect™. Outpatient lab work includes:

- Blood testing (e.g., cholesterol, CBC).
- Urine testing (e.g., urinalysis).
- Cytology and pathology (e.g., pap smears, biopsies).
- Cultures (e.g., throat culture)

Q. What tests are NOT covered under QuestSelect?

A - QuestSelect™ does not cover:

- Lab work ordered during hospitalization.
- Lab work needed on an emergency (STAT) basis and time-sensitive, esoteric outpatient laboratory testing such as fertility testing, bone marrow studies and spinal fluid tests.
- Non-laboratory work such as mammography, x-ray, imaging and dental work.
- Lab work performed without the use of your QuestSelect™ benefit.
- Testing that is not approved and/or covered by your current health benefit plan

Q. Is there a charge for specimen collection?

A - When your specimen is collected at your physician's office, any charges from the physician's office for this service are billed to your health benefit plan. Provider collection and handling fees may apply and are subject to health benefit plan provisions. Members will not be asked to pay for specimen collection out of pocket.

For a complete list of Frequently Asked Questions, please visit [QuestSelect.com](https://www.questselect.com).

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**Bartholomew
County
Public Library**

**SIMPLE.
SAFE.
SMART.**

SIGN UP TODAY

Medications FREE to your door!

CANARX is a voluntary international mail order prescription program that is available to eligible members and their dependents of Bartholomew County Public Library Employee Benefit Trust.

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

Getting started is super easy!

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

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

For More Information



1-866-893-6337
www.canarx.com
WebID: **BCPL**

TALKING POINTS

Talking about CANARX is a breeze because savings speak for themselves.



Members can enroll at no cost and receive brand-name medications—delivered for FREE from licensed pharmacies in Canada, the UK, and Australia. That's right: no copays, no shipping fees, and nothing to pay to join. Below are key CANARX highlights to share with employees. For more details, visit the FAQs at canarx.com.



ZERO copays through CANARX.

CANARX helps to keep more money in members' pockets. There are no copays, shipping charges or out-of-pocket costs to sign up. The program is FREE to members.



Signing up is fast & easy.

Members can enroll at any time, but encourage them to sign up as soon as possible to start saving. To enroll, they submit an enrollment form, a copy of their photo ID and a prescription written for a 3-month supply with 3 refills. Enrollment forms can be completed online, or a hard copy can be faxed, uploaded to our secure site or mailed to CANARX. CANARX can even help with receiving a member's prescription by reaching out to the prescriber on their behalf—they just need to ask! Please note, when taking a "new-to-you" medication, a local 30-day trial is required before ordering through the CANARX program.



Excellent customer service.

The CANARX team will call a member to welcome them to the program and then again every quarter to check in and process their refill. We like to say you get a new Canadian friend!



Worry-free refills.

Self-serve online refills are available or CANARX will reach out quarterly to ensure a continuous supply of medications.



Medications right to the member's mailbox!

Medications are shipped right to the member's mailbox. No more standing in line at the pharmacy.



Safe.

Medications are shipped in the manufacturer's sealed packaging and backed by a one-of-a-kind insurance policy through Lloyd's of London for both product and professional liability. CANARX is the only fully-insured international prescription provider in the market.



Custom member website.

Encourage members to visit their dedicated CANARX website to check their medication availability, enroll online (or download the enrollment form), watch a short program video, download a membership card and view FAQs. Still have questions? **Members can call us at 1-866-893-6337.**



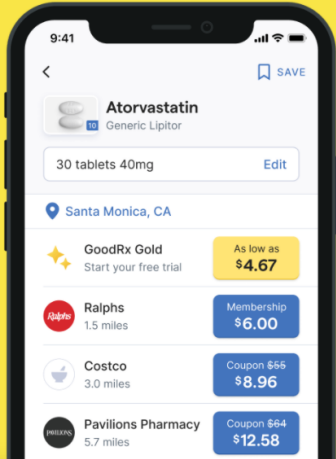
1-866-739-2718



www.canarx.com



Stop paying too much for your prescriptions. Compare prices, find coupons and save. Goodrx.com - download the mobile app.



Save up to 80% on your prescriptions with the free GoodRx app

★★★★★ 4.8-star average rating

GoodRx is the #1 most downloaded medical app on the iTunes and Google Play app stores.



Enter your mobile number to get our free app.

[Text me the app](#)

Features



Search & Compare Prices

Find the lowest local prices for your prescriptions at more than 70,000 U.S. pharmacies.



Get Free Coupons

GoodRx coupons can save you up to 80% on your prescriptions at no cost to you.



Save your prescriptions

Track prices and get notified with the latest saving alerts for your prescriptions.



Show To Your Pharmacist

It's easy, just show the GoodRx app to your pharmacist when picking up your prescription.

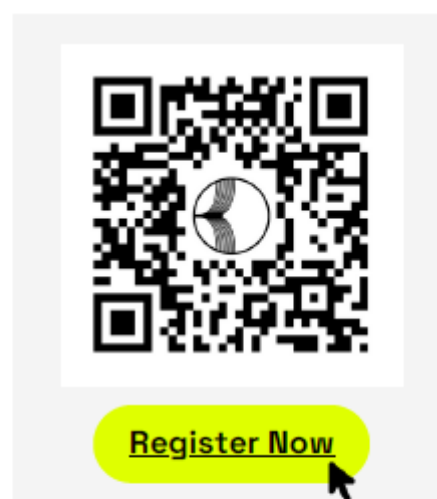
revive portal guide:

how to enroll



Enrolling with registration search

- STEP 1** Click the button below, scan the QR code or go to <https://member.myrevive.health/registration-search>
- STEP 2** You will be taken to a webpage where you will be prompted to enter a code.
Enrollment Code: **BCPLIB17**
- STEP 3** Next, enter your **First and Last Name, Date of Birth**, and either **Email Address** or **Member Identifier**.
Member Identifier:
- STEP 4** You will be taken to a page to complete the registration process to access the program. When asked, create a unique password and click Submit.
- STEP 5** You will now be sent to your personal portal to access the care services that have been selected for you.



revive[®]

urgent care.

**Emergencies are inconvenient.
Getting help shouldn't be.**

Experience 80% faster expert medical care. Save up to 100 minutes with virtual urgent care visits.



No claims/copays

Quick availability

Nationwide coverage

Continuous care

member benefit.

You have access to virtual urgent care visits.

- Care is available 24/7/365
- Rapid, same-day appointments - 94% of visits occur in less than 20 minutes
- Ability to schedule appointments for your convenience
- Exclusive provider network trained to provide the quality care you deserve
- In-person care referrals when needed



**HOW TO SCHEDULE AN
URGENT CARE VISIT**

common conditions treated.

- | | | |
|--|-----------------------------------|----------------------------|
| • Allergies | • Headaches | • Sore throat |
| • Arthritis pain | • Insect bites and stings | • Stomach ache and nausea |
| • Back or joint pain, strain or injury | • Lyme disease | • Respiratory infections |
| • Cold Sores | • Nasal or respiratory congestion | • URIs / UTIs |
| • Conjunctivitis | • Neck and back pain | • Vomiting |
| • Earaches | • Pink eye | • Your individual concerns |
| • Fever and flu | • Sinusitis | |

revive[®]

mental health.

Asking for help can be scary.
Our expert mental health care isn't.

Discover mental healthcare tailored to you. With expert guidance and personalized mental wellness plans.



No claims/copays | Consults in 1-3 days | Nationwide coverage | Provider matching

member benefit.

You have 4 virtual mental health therapy visits per member per year.

- 24/7 support (ages 12+) with a master's level clinician
- Thorough needs assessment
- Streamlined session scheduling for mental health coaching and counseling
- Rapid appointments for urgent needs

Your mental health is personal, and we keep it that way. Services are completely confidential.



common conditions treated.

- Alcohol and drug dependency
- Anxiety
- Burnout
- Child or elder care matters
- Codependency
- Daily stress
- Depression
- Eating disorders
- Physical, emotional, or sexual abuse
- Relationship concerns
- Work conflicts

Throughout the calendar year, you will be notified of how many appointments you have remaining.

Member Portal

Member Portal Instructions



ALL USERS MUST CREATE AN ACCOUNT

1. Visit www.dunnbenefit.com
2. Click on the “login” button in the upper right-hand corner of the screen
3. Here you can log in or register
4. Select “Member” from the portal drop down box
5. Enter your personal information, filling in all the required fields (marked with *)
6. Create a unique Username
7. Create a unique password
8. Submit when finished

Once submitted you will receive a message “Thanks for Registering” – please check your email to validate your account. Go to your email you entered during registration, Open your email and click on the link to complete the registration process. Then click on the button to “activate” your account.

[CLICK HERE TO ACTIVATE ACCOUNT](#)

Once your account is activated, you can proceed to login using the Username and password you created during the registration process. Once you login, you will see the following menu (left side of page).



- Home
- Claims
- Plan Summary
- Cost Estimator
- Flex
- View/Print ID Card
- Create a Request >
- Chat History
- Message Center
- Help

Welcome to Your Portal!

Save Time. Look it up Online.

Here are some of the benefits of using the portal:

- Access the information you need anytime, 24/7.
- Get your questions answered quickly by accessing the most up to date information.
- Complete a variety of transactions for yourself or on behalf of your customers.
- Download essential documents and forms you may need.
- Keep your account profile and contact information up to date.
- Get in touch with the plan administrator.

Your security is our priority. Our portal uses enhanced security features to keep your information safe. Log in to get started using your portal today. Everything you need is just a click away.

Download the Mobile App

Using your mobile device, visit www.dunnbenefit.com– scroll down to Register Now! Under the registration click on the “download our member mobile app” (google or apple). Register or Login. **Call, Message, Email Dunn & Associates for assistance!**

iPhone QR code



Android QR code



Terminology at a Glance

Your costs can vary depending on a number of factors. When calculating your costs throughout the plan year/calendar year, review your benefits on the member portal (www.dunnbenefit.com) to help confirm what you pay and what the plan pays.

Deductible – The deductible is the amount the member pays before the plan starts paying. Once the deductible has been met most plans will require you to meet a coinsurance.

Coinsurance – Percentage responsibility after deductible is met up to the out-of-pocket amount.

Example the plan pays 80% after deductible and the member pays 20% after deductible up to the out-of-pocket amount.

Out-of-Pocket – The maximum amount the member pays for covered services during the plan year. Once met, the plan will pay at 100%.

Copay – A fixed amount the member pays for services (deductible may or may not apply). Copays can vary for different services within the same plan, like prescription drugs, office visits, specialist or ER visits.

Allowed Amount – The maximum amount the plan will pay for services. If your provider charges above the allowed amount, the member may be responsible for the difference.

Annual Limit – A maximum on a benefit plan will pay in a plan/calendar year. Annual limits may be dollar limits or visit limits. After the limit has been reached, the member will be responsible for additional cost for the rest of that plan/calendar year.

Balance Billing – When a provider charges you for the difference between their charge and the allowed amount.

Example if the provider charges \$100 and the allowed amount is \$50, the member may be billed the remaining \$50. Using a provider in-network may not balance bill the member.

Coordination of Benefits – A process that determines who pays first when two or more plans are responsible for paying.

Essential Health Benefits – Services plans must cover under the Affordable Care Act. These include doctors' visits; inpatient and outpatient hospital care; prescription drugs, pregnancy/childbirth; mental health services and more. Services may vary based on the members' state requirements.

Open Enrollment – the annual period when members can enroll in the plan.

Formulary – In regard to your Prescription drug plan. The formulary is a list of prescription drugs covered by the plan. Please visit your Pharmacy Benefit Manager's website for a current formulary list.

Generic Drug - A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

Group Health Plan – A plan offered by an Employer that provides health care coverage to employees and their dependents. Group Health care coverage could include medical, prescription drug, dental and or vision coverage.

Health Savings Account - A savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in an HSA to pay for deductibles, copayments, coinsurance, and some other expenses, you may be able to lower your out-of-pocket health care costs. HSA funds generally may not be used to pay premiums. While you can use the funds in an HSA at any time to pay for qualified medical expenses, you may contribute to an HSA only if you have an HSA-eligible plan (sometimes called a High-Deductible Health Plan (HDHP)) — generally a health plan (including a Marketplace plan) that only covers preventive services before the deductible. An HSA may earn interest or other earnings, which are not taxable. Banks, credit unions, and other financial institutions offer HSAs.

Terminology at a Glance

High-Deductible Health Plan (HDHP) - A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (also called your deductible). A high-deductible plan can be combined with a health savings account (HSA), for you to pay for certain medical expenses with money you set aside in your tax-free HSA. This is why it's more commonly called an HSA-eligible plan.

In-Network/Out-of-Network – In-network is a list of providers that contract with your Preferred Provider Organization (PPO) utilized by the group health plan. In-network out of pocket costs are usually less than out-of-network providers. Out-of-network providers are providers who do not participate in your PPO.

Lifetime – A maximum on a benefit plan will pay in a member's lifetime. Lifetime limits may be dollar limits or visit limits. After the limit has been reached, the member will be responsible for additional cost for the rest of their time covered by this plan.

Open Enrollment Period – The annual period when members can enroll in the health plan.
Example (December 1 to December 31 with an effective date of January 1).

Preferred Provider – A provider who has contracted with your PPO/plan (in-network) who have agreed to provide services at a discount. Visit your PPO's website for a list of preferred providers.

Preferred Provider Organization (PPO) – a health plan vendor that contracts with health care providers (hospitals and doctors) to create a network or participating providers. Members cost could be less if utilizing a provider in the PPO.

Preventative Services – routine health care that includes screenings, check-ups, and counseling to prevent illnesses, disease or other health conditions.

Prior Authorization/Precertification – A decision received by your health plan that a health care service, treatment plan, or prescription drug are medically necessary. The plan may require prior authorization or precertification for services before you receive them. Refer to the ID Card or Summary Plan Description booklet for details.

Primary Care Physician – A medical Doctor or Doctor of Osteopathic Medicine who directly provides or coordinates health care services for a member.

Qualifying Event – A change in your life such as, marriage, a birth or loss of coverage that can make you eligible for a special enrollment, allowing the member to enroll in the plan outside of the Open Enrollment period.

Specialist – A doctor that specializes in a specific area of medicine or group of patients to diagnose, manage, prevent or treat specific types of symptoms or conditions.

Usual, Customary & Reasonable – the amount paid for a service in a geographic area on what providers in the area charge for the same service. The UCR is often used to determine the allowed amount.

Waiting Period – the period of time that must pass before coverage can be effective for a member who is eligible for coverage under the plan. Example – 1st of the month following 90 days.

Medicare Part D – Creditable Coverage – Benefit Tips

What is the Medicare Part D Penalty?

If you are eligible for Medicare Part D and you **do not** enroll timely for Part D coverage, you may incur a 1% per month penalty when you sign up for Part D at a later date. Example: If you are eligible for Part D at 65 and wait until age 70 to sign up without creditable coverage, waiting 5 years or 60 months x 1% would lead to a 60% penalty on the base Part D rate.

How do I avoid the Medicare Part D penalty?

A late enrollment penalty of 1% per month applies to individuals who do not maintain Medicare equivalent creditable coverage for a period of 63 continuous days or longer following their initial enrollment period for Medicare Part D.

- You may want to enroll in Part D while also being covered by a group health plan that is primary.
- Or elect to disenroll from your group health plan and enroll in all parts of Medicare. It is always your choice, not your employers.

I (or a spouse) am Medicare eligible for Medicare Part D; how do I know if my plan is creditable?

Each year your group health plan determines if its prescription drug plan is creditable and provides a Medicare Part D Creditable Coverage Notice to all individuals (October 14th). This annual Creditable Coverage Notice deadline is just prior to the beginning of the Medicare annual enrollment window. **It is important to pay attention to this notice if you are over 65.**

Is my employer plan required to be creditable?

No, and it may change each year. In late 2024 the Biden Administration changed the Part D Creditability Test Calculation which will make many more employer or group health plans no longer Creditable in 2026.

IMPORTANT: IT IS YOUR RESPONSIBILITY TO SIGN UP FOR MEDICARE PART D IN A TIMELY MANNER IF YOU WISH TO AVOID THE PENALTY.

If my plan was creditable last year, can I assume it will be creditable again this year?

No, Your employer plan must perform a Part D credibility test each year comparing its pharmacy coverage to Medicare Part D benefits to determine the credibility status. The changes in the Part D calculation formula are expected to change the credibility status of a large number of employer health plans in 2026. The new credibility requirement by design will force many individuals to either start paying for Part D coverage earlier than they would have or pay more in premiums later (via the penalty surcharge) to support Medicare and offset rising drug costs.

What are my options?

If your employer plan is not creditable next year and you are eligible for Medicare, you will want to consider signing up for Part D to avoid the penalty. You should meet with a Medicare insurance professional to evaluate your individual situation and understand your Part D cost or penalty risk. Everyone's situation will be different.

Your employer is not responsible for any potential penalties you or your spouse incurs if you fail to enroll timely in Medicare Part D.

Annual Compliance Notices

- ✓ Patient Protection and Affordable Care Act
- ✓ Prescription Drug Coverage and Medicare
- ✓ CHIP
- ✓ Paperwork Reduction Act
- ✓ Continuation of Coverage (COBRA)
- ✓ Special Enrollment Rights
- ✓ Women's Health and Cancer Rights Act
- ✓ Newborns and Mothers Health Protection Act
- ✓ Grandfathered Status under Healthcare Reform Act
- ✓ Providers Choice
- ✓ USERRA Health Insurance Protection
- ✓ Protections From Disclosure of Medical Information
- ✓ Wellness Plan – (if applicable)
- ✓ HHS Non-Discrimination Notice
- ✓ Exchange (Marketplace) Notice
- ✓ Privacy Notice

Patient Protection and Affordable Care Act (PPACA)

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

Enrollment Opportunity: Lifetime Limit No Longer Applies

The Lifetime Limit on the dollar value of benefits under the plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan.

Enrollment Opportunity: Extension of Dependent Coverage to Age 26 Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent children ended before attainment of age 26 regardless of whether they are eligible for other health coverage (employer-sponsored or otherwise); are eligible to enroll in the plan. Individuals may request enrollment for such children during the enrollment period. For more information, please contact your Human Resource Department. A plan that covers an Adult Child as an Employee or a Spouse will be primary to a plan that covers the Adult Child as a dependent child.

Patient Protection Disclosure:

This plan does not require the designation of a primary care provider. You have the right to seek care from any primary care provider of your choice. Designation of a primary care physician is not required for children. You do not need prior authorization from this plan or Dunn and Associates Benefit Administrators, Inc. or from any other person (including a primary care physician) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a preapproved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in primary care, pediatrics, obstetrics, or gynecology, contact Dunn and Associates Benefit Administrators at 812-827-2429 or 800-880-9960 or visit www.dunnbenefit.com.

Grandfathered Plan Status:

This group health plan believes this Plan is a “Non-Grandfathered Plan” under the PPACA. Being a non-grandfathered plan means that this Plan does include certain consumer protections under the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a non-grandfathered health plan and what might cause a plan to change from a grandfathered health plan status can be directed to the plan supervisor, Dunn and Associates Benefit Administrators at 812-827-2429 or 800-880-9960.

Prohibition of Rescissions:

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

Prohibition on Preexisting Condition Exclusions:

PPACA prohibits a group health plan from denying coverage based on an applicant’s preexisting condition.

Preventative Care:

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

Emergency Services:

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

Clinical Trials:

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

Revised Appeals Process:

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

Important Notice About Your Prescription Drug Coverage and Medicare

Bartholomew County Public Library – PPO Plan

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

1. Medicare prescription drug coverage became available in 2007 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage they offer is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage. Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you do decide to enroll in a Medicare prescription drug plan and drop your employer's prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan. You should also know that if you drop or lose the coverage with your employer and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

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

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, and if the coverage through your employer changes. You may also request a copy.

For more information about your options under Medicare prescription drug coverage...

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

For more information about Medicare prescription drug plans:

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

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

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 2025
Name of Entity/Sender:	Bartholomew County Public Library
Contact/Position/Office:	Michelle Williams/Joe Joyner
Address:	536 5 th St. Columbus, IN 47201
Phone Number:	(812) 379-1252

Important Notice About Your Prescription Drug Coverage and Medicare

Bartholomew County Public Library – HDHP

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

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

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage may or may not be affected. If you drop your current drug plan and enroll in Medicare drug coverage you may enroll back into the benefit plan during the open enrollment period. For More Information about this Notice Or Your Current Prescription Drug Coverage contact your Employer. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through your employer changes. You also may request a copy of this notice at any time. For More Information About Your Options Under Medicare Prescription Drug Coverage more detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
 - Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
 - Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	October 2025
Name of Entity/Sender:	Bartholomew County Public Library
Contact/Position/Office:	Michelle Williams
Address:	536 5 th St. Columbus, IN 47201
Phone Number:	(812) 379-1252

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

Health Insurance Premium Payment Program/All Other Medicaid
Website: <https://www.in.gov/medicaid>
<http://www.in.gov/fssa/dfr/>
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

Paperwork Reduction Act

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The department notes that a federal agency cannot conduct or sponsor a collection of information unless it is approved by the OMB under the PRA and displays a valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number see 44 U.S.C. 3512. The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the US Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebbsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Continuation of Coverage under COBRA

Employers who employ 20 or more employees are subject to the continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation of coverage can become available to you and other members of your family when group health coverage would otherwise end because of certain qualifying events such as a termination of employment for reasons other than gross misconduct, reduction in hours, divorce, legal separation, death or a child ceasing to meet the definition of a dependent under the group health plan. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse, and your dependent children could become qualified beneficiaries if group health plan coverage is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out of pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. For information about your rights and obligations under COBRA, you should review the Plan's Summary Plan Description or contact the plan administrator.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents other coverage). However, you must request enrollment 30 days after you or your dependents other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent, because of marriage, birth, adoption or placement for adoption you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or CHIP, or when you and your dependents gain eligibility for state premium assistance. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy. To request special enrollment or obtain more information, contact the plan administrator.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for, all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedema. Benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. If you would like more information on WHCRA benefits, contact the plan administrator.

Newborns and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable). In any case, plans and issuers may not, under Federal law require that a provider obtain prior authorization from the plan or the insurance issuer for prescribing a length of stay in excess of 48 hours (or 96 hours if applicable).

Grandfathered Status Under Healthcare Reform

This group health plan believes this Plan is a “Non-Grandfathered Plan” under the PPACA. Being a non-grandfathered plan means that this Plan does include certain consumer protections under the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a non-grandfathered health plan and what might cause a plan to change from a grandfathered health plan status can be directed to the plan supervisor, Dunn and Associates Benefit Administrators at (800) 880-9960. Questions regarding which protections apply and which protections do not apply to a non-grandfathered health plan and what might cause a plan to change status can be directed to the plan administrator. US Department of Labor (866) 444-3272 or www.dol.gov/healthreform. This website has a table summarizing which protections do and do not apply.

USERRA Health Insurance Protection

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. If you leave your job to perform military services, you have the right to elect to continue your existing coverage for you and your dependents for up to 24 months while in the military. Even if you don’t elect to continue coverage during your service you have the right to be reinstated in your employer’s health plan when you are reemployed, generally without any waiting periods or exclusions except for service connected illnesses or injuries. For more information about your rights to continue your coverage, contact the plan administrator.

Protections from Disclosure of Medical Information (if applicable)

We are required by law to maintain the privacy and security of your personal identifiable health information. Although the plan may use aggregate information it collects to design a program based on identified health risks in the workplace, it will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to request from you for a reasonable accommodation need to participate in any wellness program (if applicable) or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with any wellness program will not be provided to your employer and may never be used to make decisions regarding your employment. Your health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law to carry out specific activities related to any wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in any wellness program or receiving any incentives. Anyone who receives your information for the purpose of providing you services as part of any wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable information is/are in order to provide you with services under any wellness program. In addition, all information obtained from any wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of any wellness program will be used in making an employment decision. Specify any other or additional confidentiality protections if applicable. Appropriate precautions will be taken to avoid any data breach and in the event a data breach occurs involving information you provide in connection with any wellness program we will notify you immediately. You may not be discriminated against in employment because if the medical information you provide as participating in any wellness program nor may you be subjected to retaliation if you choose not to participate. If you have any questions regarding this notice or about protections against discrimination/retaliation, please contact the plan administrator.

Wellness Plan Alternative Standard (if applicable)

Your health plan is committed to helping you achieve your best health. Rewards for participating in any wellness program may be available to employees. If you think you might be unable to meet a standard for a reward under any wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your employer and they will work with you to find an alternative that is right for you, for the same reward considering your health issue(s).

HHS Non-Discrimination Notice

The U.S. Department of Health and Human Services (HHS) complies with applicable Federal civil rights laws and does not discriminate on the base of race, color, national origin, age, disability, or sex. HHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. HHS provides free aids and services to people with disabilities to communicate effectively with us such as; Qualified sign language interpreters and Written information in other formats (large print, audio, accessible electronic formats, other formats), Provides free language services to people whose primary language is not English such as Qualified interpreters and Information written in other languages. If you need these services, contact HHS at, 1 (877) 696-6775. If you believe HHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights compliant portal, by mail or phone. Complaint forms are also available at <http://www.hhs.gov/ocr/office/file/index.html>

US Department of Health and Human Services
200 Independence Avenue, SW - Room 509F, HHH Building
Washington, DC 20201
1 (800) 368-1019 or 1 (800) 537-7697 (TDD)

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.
Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.



Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

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

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

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.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 Bartholomew County Public Library		4. Employer Identification Number (EIN) 35-1963787	
5. Employer address 536 5th St.		6. Employer phone number 812-379-1252	
7. City Columbus	8. State Indiana	9. ZIP code 47201	
10. Who can we contact at this job? Michelle Williams or Joe Joyner			
11. Phone number (if different from above)	12. Email address mwilliams@mybcpl.org jjoyner@mybcpl.org		

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