HOOSIER HEARTLAND SCHOOL TRUST

August 1, 2021

Dear Hoosier Heartland School Trust Medical Plan Members,

The HHST Board of Trustees would like to announce the completion of our September 1, 2021 Group Health Plan renewal with an overall increase of 2%. A blended Medical and Pharmacy trend is running 11%, with Indiana schools averaging 7.5%.

The Trust medical plan is a self-funded plan, meaning each member has ownership in the success of the Trust. The dominant driver of our premium costs are the healthcare claims of all covered members. Your active participation in managing your own health conditions and making healthy lifestyle choices can have a positive impact on claims and premiums. We encourage those with clinic access to save claim expenses by using the clinics when possible. Using the clinics can save you and the Trust significant claim dollars. All covered members also have access to our telemedicine option - First Stop Health (FSH). FSH is a telemedicine benefit for medical and mental health services with no member out-of-pocket cost. You can access this benefit by calling 888-691-7867 or visiting app2.fshealth.com.

Our Annual Open Enrollment/Plan Selection Period will be held from August 1 through August 31, 2021. This is the time for you to confirm or change your plan selection for September 1, 2021 – August 31, 2022. If you previously declined coverage, this is your opportunity to enroll effective September 1, 2021. Failure to enroll during the Open Enrollment Period will forfeit any future enrollment rights until the next annual open enrollment period, unless you or an eligible dependent experience a HIPAA qualifying event. As a reminder, your deductibles and out-of- pocket maximums will reset January 1.

All the information you need to make your plan selection has been included in your Open Enrollment/Plan Selection Packet. **Please read the material carefully and complete all steps no later than August 31, 2021.**

A Summary of Benefits and Coverage (SBC) for each plan has been posted on our Trust website at mybensite.com/hoosier. A printed copy of the SBCs will be provided to you free of charge upon request.

Important information

UnitedHealthcare (UHC):

- Our Plan Administrator is UnitedHealthcare (UHC)
  - Group # 0914985
  - Customer Service Number for HDHP Members (800) 864-9427 & PPO Members (866) 633-2474
- Your Trust Medical Plan benefits will remain unchanged. If you change plans, you will receive credit for applicable deductible or out-of-pocket expenses you have accumulated so far in 2021 up to new plan maximums.
- You will only receive a new ID card if you add or drop dependents, or if you make a plan change. Please be on the lookout in the mail for a plain envelope, coming from UHC, your cards will be enclosed. If you need additional ID cards, you may register on the myuhc.com website and request additional cards. You may also print a card for your immediate use. The MYUHC App also houses your ID card for immediate access.
- The UHC network, Choice Plus, is the largest in the nation. It is your responsibility to verify your provider is in network. Search the provider network at myuhc.com, call UHC Customer Service, or contact your healthcare provider directly.

First Stop Health

- The Trust provides a no-cost Virtual Visit for medical and mental health needs. Contact First Stop Health (FSH) at 888-691-7867 or app2.fshealth.com.

RxBenefits (Prescription):

- Our prescription provider is with RxBenefits. You may utilize any pharmacy in the CVS Caremark Network. A listing can be found on the caremark.com website. If you use mail-order for your prescriptions, the CVS mail-order form can be found on the Trust website at mybensite.com/hoosier or at caremark.com. Your Caremark Group Number is RX2169. Should you need to contact customer service with any concerns, their number is (800) 334-8134.

Please review the SBCs for complete plan details.

2021 BENEFITS	PPO 1 Network/Non	PPO 2 Network/Non	HDHP 1 HSA Eligible Network/Non	HDHP 2 HSA Eligible Network/Non
Deductible	**Medical**	**Medical**	**Medical/Rx**	**Medical/Rx**
Single	$750 / $1,500	$1,500/ $4,500	$3,400 / $6,800	$6,000 / $12,000
Family	$1,500 / $3,000	$3,000 / $9,000	$6,750 / $13,500	$12,000 / $24,000
Out-of-Pocket Maximum	**Medical**	**Medical**	**Medical/Rx**	**Medical/Rx**
Single	$2,000 / $4,000	$3,500 / $10,500	$5,000 / $10,000	$6,550 / $24,000
Family	$4,000 / $8,000	$7,000 / $21,000	$10,000 / $20,000	$13,100 / $48,000
Prescriptions	**Rx Only**	**Rx Only**	**Deductible Applies First**	**Deductible Applies First**
Annual Out-of-Pocket Max				
Single	$5,150	$3,650	**Combined with Medical**	**Combined with Medical**
Family	$10,300	$7,300		
Retail				
Tier 1 Generics	> of $12 or 20% max $50	> of $12 or 20% max $50	> of $12 or 20% max $50	> of $12 or 20% max $50
Tier 2 Formulary	> of $25 or 20% max $50	> of $25 or 20% max $50	> of $25 or 20% max $50	> of $25 or 20% max $50
Tier 3 Non-Formulary	> of $50 or 20% max $50	> of $50 or 20% max $50	> of $50 or 20% max $50	> of $50 or 20% max $50
Tier 4 Specialty Meds	$100	$100	$100	$100
Mail Order – Network Only				
Tier 1 Generics	> of $24 or 20% max $100	> of $24 or 20% max $100	> of $24 or 20% max $100	> of $24 or 20% max $100
Tier 2 Formulary	> of $50 or 20% max $100	> of $50 or 20% max $100	> of $50 or 20% max $100	> of $50 or 20% max $100
Tier 3 Non-Formulary	> of $100 or 20% max $100	> of $100 or 20% max $100	> of $100 or 20% max $100	> of $100 or 20% max $100
Tier 4 Specialty Meds	$100	$100	$100	$100

UHC and the Trust offer great on-line resources. Among other things, these tools allow you to search for providers, order an ID card, print an ID card, check your claim and prescription status, compare benefit options and price shop for quality care. We encourage you to visit these sites for additional information on your benefits.

myuhc.com caremark.com
mybensite.com/hoosier

TELEMEDICINE OPTION
app2.fshealth.com

RE Sutton & Associates, Inc.
Diane Titchenell, Trust Administrator
Dtitchenell@bbindy.com

Hoosier Heartland School Trust
9/1/2021-8/31/2022 Benefit Plan Options

	PPO 1	**PPO 2**	**HDHP 1**	**HDHP 2**
	Network / Non-Network	***Network / Non-Network***	***Network / Non-Network***	***Network / Non-Network***
Deductible - Individual - Family	 $750 / $1,500 $1,500 / $3,000	 $1,500 / $4,500 $3,000 / $9,000	 $3,400 / $6,800 $6,750 / $13,500	 $6,000 / $12,000 $12,000 / $24,000
Co-Insurance %	20% / 40%	20% / 40%	0% / 30%	0% / 30%
OOP Max (Incl. Ded) - Individual - Family	 $2,000 / $4,000 $4,000 / $8,000	 $3,500 / $10,500 $7,000 / $21,000	 $5,000 / $10,000 $10,000 / $20,000	 $6,550 / $24,000 $13,100 / $48,000
Routine Care	100% (no ded) Network Only	100% (no ded) Network Only	100% (no ded) / 30%	100% (no ded) / 30%
Prescriptions Annual OOP Maximum: - Individual - Family	 $5,150 $10,300	 $3,650 $7,300		
Retail Tier 1 - Generics Tier 2 - Formulary Tier 3 - Non-Formulary Tier 4 - Specialty Meds[3]	 > of $ 12 or 20% max $50 > of $ 25 or 20% max $50 > of $ 50 or 20% max $50 $100	 > of $ 12 or 20% max $50 > of $ 25 or 20% max $50 > of $ 50 or 20% max $50 $100	DEDUCTIBLE FIRST > of $ 12 or 20% max $50 > of $ 25 or 20% max $50 > of $ 50 or 20% max $50 $100	DEDUCTIBLE FIRST > of $ 12 or 20% max $50 > of $ 25 or 20% max $50 > of $ 50 or 20% max $50 $100
Mail Order - *Network Only* Tier 1 Generics Tier 2 Formulary Tier 3 Non-Formulary Tier 4 Specialty Meds[3]	 > of $ 24 or 20% max $100 > of $ 50 or 20% max $100 > of $100 or 20% max $100 $100	 > of $ 24 or 20% max $100 > of $ 50 or 20% max $100 > of $100 or 20% max $100 $100	 > of $ 24 or 20% max $100 > of $ 50 or 20% max $100 > of $100 or 20% max $100 $100	 > of $ 24 or 20% max $100 > of $ 50 or 20% max $100 > of $100 or 20% max $100 $100
RATES 09/01/21-08/31/22				
EE	$1,232	$935	$830	$697
EE /Child(ren)	$1,959	$1,577	$1,376	$1,148
EE/Spouse	$2,517	$1,987	$1,744	$1,465
Family	$3,208	$2,525	$2,244	$1,883

NOTES:

(1) To comply with ACA requirements, all plans must include a combined OOP maximum for both medical and prescription drug coverage – single - $8,550 / Family - $17,100;
(2) HDHP 1 and HDHP 2 are IRS qualified plans
(3) On HDHP 1 and HDHP 2 – difference between deductible and out of pocket amounts are accumulated only by additional pharmacy co-pays or coinsurances. Once deductible is met on medical, all medical services are paid at 100%. Pharmacy cost share will continue up to maximum out of pocket amounts.
(4) HDHP 2 is considered Non-Credible as it relates to Medicare Part D requirements. If Medicare eligible, HDHP 2 is not a qualified plan and penalties with Medicare D may apply,
(5) Please refer to your SBC (Summary of Benefit Coverage) and certificate booklet for further details.
(6) PPO 1 and PPO 2 have 4th quarter deductible carryover.
(7) UnitedHealthcare is administering the medical portion of the health plan. RxBenefits/CVS is administering the pharmacy portion.
(8) 24/7 First Stop Health including mental health option and PriceMD Specialty Program Included in Trust Benefits

Hoosier Heartland School Trust
9/1/2021-8/31/2022 Benefit Plan Options

	PPO 1	**PPO 2**	**HDHP 1**	**HDHP 2**
	Network / Non-Network	***Network / Non-Network***	***Network / Non-Network***	***Network / Non-Network***
Deductible - Individual - Family	 $750 / $1,500 $1,500 / $3,000	 $1,500 / $4,500 $3,000 / $9,000	 $3,400 / $6,800 $6,750 / $13,500	 $6,000 / $12,000 $12,000 / $24,000
Co-Insurance %	20% / 40%	20% / 40%	0% / 30%	0% / 30%
OOP Max (Incl. Ded) - Individual - Family	 $2,000 / $4,000 $4,000 / $8,000	 $3,500 / $10,500 $7,000 / $21,000	 $5,000 / $10,000 $10,000 / $20,000	 $6,550 / $24,000 $13,100 / $48,000
Routine Care	100% (no ded) Network Only	100% (no ded) Network Only	100% (no ded) / 30%	100% (no ded) / 30%
Prescriptions Annual OOP Maximum: - Individual - Family	 $5,150 $10,300	 $3,650 $7,300	 	
Retail Tier 1 - Generics Tier 2 - Formulary Tier 3 - Non-Formulary Tier 4 - Specialty Meds	 > of $ 12 or 20% max $50 > of $ 25 or 20% max $50 > of $ 50 or 20% max $50 $100	 > of $ 12 or 20% max $50 > of $ 25 or 20% max $50 > of $ 50 or 20% max $50 $100	DEDUCTIBLE FIRST > of $ 12 or 20% max $50 > of $ 25 or 20% max $50 > of $ 50 or 20% max $50 $100	DEDUCTIBLE FIRST > of $ 12 or 20% max $50 > of $ 25 or 20% max $50 > of $ 50 or 20% max $50 $100
Mail Order - *Network Only* Tier 1 Generics Tier 2 Formulary Tier 3 Non-Formulary Tier 4 Specialty Meds	 > of $ 24 or 20% max $100 > of $ 50 or 20% max $100 > of $100 or 20% max $100 $100	 > of $ 24 or 20% max $100 > of $ 50 or 20% max $100 > of $100 or 20% max $100 $100	 > of $ 24 or 20% max $100 > of $ 50 or 20% max $100 > of $100 or 20% max $100 $100	 > of $ 24 or 20% max $100 > of $ 50 or 20% max $100 > of $100 or 20% max $100 $100

NOTES:

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(3) On HDHP 1 and HDHP 2 – difference between deductible and out of pocket amounts are accumulated only by additional pharmacy co-pays or coinsurances. Once deductible is met on medical, all medical services are paid at 100%. Pharmacy cost share will continue up to maximum out of pocket amounts.
(4) HDHP 2 is considered Non-Credible as it relates to Medicare Part D requirements. If Medicare eligible, HDHP 2 is not a qualified plan and penalties with Medicare D may apply,
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(7) UnitedHealthcare is administering the medical portion of the health plan. RxBenefits/CVS is administering the pharmacy portion.
(8) 24/7 First Stop Health including mental health option and PriceMD Specialty Program Included in Trust Benefits

Dependent Eligibility Requirement For HHST Group Health Plan Participants

Effective September 1, 2011, Hoosier Heartland School Trust began requiring documentation for dependent eligibility verification on all new enrollees adding spouses and/or children at the time of enrollment.

Eligible dependents are defined by the benefits summary as:

- ✓ Your spouse as recognized under the laws of the State of Indiana.
- ✓ Your dependent *child** up to age 26.
- ✓ Your dependent *child** who cannot work to support him/herself due to mental or physical handicap. Eligibility continues past the age limit if the child is already enrolled and is allowed as a federal tax exemption by you or your spouse.

A *child** is defined as your own child, stepchild, legally adopted child (or placed for adoption), child for whom you or your spouse has court ordered legal guardianship, or a child for whom you are required to provide health insurance by a Qualified Medical Child Support Order.

Required Documents for Dependent Verification:

All Required Documents **MUST** include date and/or year, member name and dependent's name.

IMPORTANT: Please black out all Social Security numbers, account numbers as well as any financial or income information.

For Spouse: Provide copies of 2 forms of documentation listed below.

- ✓ *A copy of marriage certificate **AND***
- ✓ *A copy of the front page of a current federal tax return confirming the dependent as a spouse, **OR** a document dated within the last 6 months showing current relationship status such as a joint household bill, joint bank/credit account, joint mortgage/lease, or insurance policies. The document must list employee and spouse's name, the date, and mailing address.*

For Children under age 26: Provide copy of 1 form of documentation.

- ✓ *A copy of the child's birth certificate, naming employee or spouse as the child's parent, or appropriate court order / adoption decree naming employee or spouse as the child's legal guardian.*

Note for Stepchildren: If you are covering a stepchild and the child's parent is not a covered dependent, in addition to the item(s) required for children above, you must also provide documents required for a spouse as proof of your relationship to the child's parent.

9/1/2021

Dependent Eligibility & Documentation Requirement
HHST Group Health Plan Participants

Group Health Plan Eligibility & Documentation

Eligible Subscriber

- ✓ An employee or early retiree of a Trust participating school corporation
- ✓ Must be eligible to participate in the Trust group health plan as defined by local and/or Trust wide criteria
- ✓ Must satisfy any applicable probationary period established by the employer

Dependents

- ✓ Spouse – a spouse that is legally recognized in the state of Indiana
- ✓ Children – your natural children, stepchildren, newborn child, child for whom you have legal guardianship or a legally adopted child, child for whom you have a "qualified Medical Child Support Order" or as otherwise required by law; children may remain covered until the end of the month in which they attain age 26

  Eligibility is continued past age 26 for children *already enrolled as dependents* who cannot work to support themselves due to mental or physical handicap. The disability must start before the end of the period when they would have become ineligible. The Plan will require periodic recertification of the child's disability.

Effective September 1, 2011, Hoosier Heartland School Trust began requiring documentation for dependent eligibility verification on all new enrollees adding spouses and/or children at the time of enrollment.

Eligible dependents are defined by the benefits summary as:

- ✓ Your spouse as recognized under the laws of the State of Indiana.
- ✓ Your dependent *child** up to age 26.
- ✓ Your dependent *child** who cannot work to support him/herself due to mental or physical handicap. Eligibility continues past the age limit if the child is already enrolled and is allowed as a federal tax exemption by you or your spouse.

A *child** is defined as your own child, stepchild, legally adopted child (or placed for adoption), child for whom you or your spouse has court ordered legal guardianship, or a child for whom you are required to provide health insurance by a Qualified Medical Child Support Order.

Required Documents for Dependent Verification:

All Required Documents **MUST** include date and/or year, member name and dependent's name.

IMPORTANT: Please black out all Social Security numbers, account numbers as well as any financial or income information.

For Spouse: Provide copies of 2 forms of documentation listed below.

- ✓ *A copy of marriage certificate **AND***
- ✓ *A copy of the front page of a current federal tax return confirming the dependent as a spouse, **OR** a document dated within the last 6 months showing current relationship status such as a joint household bill, joint bank/credit account, joint mortgage/lease, or insurance policies. The document must list employee and spouse's name, the date, and mailing address.*

For Children under age 26: Provide copy of 1 form of documentation.

- ✓ *A copy of the child's birth certificate, naming employee or spouse as the child's parent, or appropriate court order / adoption decree naming employee or spouse as the child's legal guardian.*

Note for Stepchildren: If you are covering a stepchild and the child's parent is not a covered dependent, in addition to the item(s) required for children above, you must also provide documents required for a spouse as proof of your relationship to the child's parent.

9/1/21

HOOSIER HEARTLAND SCHOOL TRUST
EMPLOYEE ENROLLMENT FORM

Madison Special Services Use Only		
Employee Date of Hire:	Employee Occupation:	Coverage Effective Date:
Is Income Reported by W-2?	Hours Worked Per Week:	Retirement Date:

Section A – Waiver of Coverage (*This section must be completed for employee and / or any eligible dependent not enrolling the group health plan when initially eligible due to coverage elsewhere)*

Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage
Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage
Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage
Name of person waiving:	Coverage is provided by [ ] Spouse [ ] Parent [ ] No Coverage

I certify that I have been given an opportunity to apply for group health coverage through the Trust and I am declining as indicated above. I understand that I will be able to enroll in the future only during the next annual open enrollment period, OR if I or my eligible dependent(s) experience a qualifying event as defined by HIPAA guidelines. I also understand that if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents at that time. All enrollment forms must be received within *31* days of the event.

Employee Signature _____ **Date** _____

Section B – Medical Coverage Selection Information

Circle One	**Active 0157**	**Retiree 0161**	**COBRA 0165**	**Active 0158**	**Retiree 0162**	**COBRA 0166**	**Active 0159**	**Retiree 0163**	**COBRA 0167**	**Active 0160**	**Retiree 0164**	**COBRA 0168**
Employee	☐ **PPO 1**			☐ **PPO 2**			☐ **HDHP 1**			☐ **HDHP 2**		
EE/Child(ren)	☐ **PPO 1**			☐ **PPO 2**			☐ **HDHP 1**			☐ **HDHP 2**		
EE/Spouse	☐ **PPO 1**			☐ **PPO 2**			☐ **HDHP 1**			☐ **HDHP 2**		
Family	☐ **PPO 1**			☐ **PPO 2**			☐ **HDHP 1**			☐ **HDHP 2**		

Section C – Employee/Application Information (all fields must be completed)

First Name	MI	Last Name	Social Security #	Sex ☐ M ☐ F	Date of Birth mm/dd/yyyy	☐ Single ☐ Married ☐ Divorced
Home Address (include PO Box if applicable)		City		State		Zip
Home Phone ( )		Work Phone ( )				
Email Address			Document Preference ☐ NO PRERENCE ☐ ONLINE ☐ PAPER			

Section D – Spouse Information (all fields must be completed)

First Name	MI	Last Name	Social Security #	Sex ☐ M ☐ F	Date of Birth mm/dd/yyyy

Is your spouse employed?

☐ Yes If yes, please provide name of employer:_____

☐ No

Does your spouse have medical coverage through his/her employer?

☐ Yes

☐ No

Section E – Family Information – (all fields must be completed for each covered dependent)

First Name	MI	Last Name	Social Security #	Relationship / Sex: ☐ Child ☐ Male ☐ Other ☐ Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: ☐ Child ☐ Male ☐ Other ☐ Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: ☐ Child ☐ Male ☐ Other ☐ Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: ☐ Child ☐ Male ☐ Other ☐ Female	Date of Birth mm/dd/yyyy
First Name	MI	Last Name	Social Security #	Relationship / Sex: ☐ Child ☐ Male ☐ Other ☐ Female	Date of Birth mm/dd/yyyy

Section F – Other Health Coverage

List yourself and any family members to be enrolled in this plan who will be covered by other health coverage on this plan's effective date:

Provide name & address of insurance carrier:_____

Policyholder Name:_____ Relationship to Employee:_____

Group/Account/Policy ID Number:_____ Effective Date of Coverage:_____

If you and/or your dependent(s) are enrolled in Medicare or Medicaid, please complete the following:

Enrollees Name:	Medicare/Medicaid ID #	Medicare Part A Effective Date:	Medicare Part B Effective Date:

Section G – Prior Health Coverage

Have you or other family members to be enrolled in this plan had other coverage in the past 2 years?

☐ Yes (*complete information below)*

☐ No

List yourself and any other family members who have had prior coverage:	Name of Insurance Carrier: Group/Account/Policy ID Number: Coverage Effective Date: Coverage Termination Date: Reason for Termination: ☐ Divorce/Legal Separation ☐ Death of Spouse ☐ COBRA Coverage Exhausted ☐ Termination of Employment ☐ Employer Premium Contribution Ceased ☐ Other - Please explain_____ _____

If the relationship of a dependent is an adopted child or child for whom you have legal custody, you must provide a copy of legal documentation. All enrollments must be submitted within *31* days of the qualifying event. All required documentation must accompany this form in order to process the enrollment.

By signature, I declare that the information provided is complete and correct. By electing coverage under this Plan, I also agree to have the applicable premium deductions made. I accept that I am responsible to notify my employer of any change that would make me or any dependent ineligible for benefits under the Trust group health plan.

Employee Signature: _____ **Date:** _____

Your coverage is issued by a multiple employee welfare arrangement. The multiple welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State guaranty funds are not available for your multiple employer welfare arrangement.

HHST Office Use Only

Spouse: Marriage Certificate _____ **Child:** Birth Certificate _____ UHC _____

Current Tax/Bill Doc _____ Court Order/Adoption Decree _____ 2020/2021

Thinking About HDHP 1 or HDHP 2?

While there is an element of cost savings to the overall HHST health plan, the advantages of the HDHP/HSA can be *significant* for those who have selected this health plan choice.

The High Deductible Health Plan (HDHP) is simply that, a comprehensive health plan that includes a higher deductible than what is typical with a traditional plan design. HDHPs are approved by the IRS to be partnered with an individual Health Savings Account *(HSA). Another difference between an IRS-qualified HDHP and a traditional plan is that ALMOST ALL eligible plan expenses are subject to the deductible, including prescriptions. That means the member will pay the full cost of care until the deductible has been reached. The only exception is that age appropriate routine preventive care services are NOT subject to the deductible and are covered by the plan with no member cost share required.

Benefits of an HDHP/HSA

- HDHP premiums are lower than traditional plans.
- Many HHST members also have access to a Trust-sponsored wellness clinic where certain primary care services, lab services, and generic medications are available at no charge.
- The HSA belongs to you so wherever you go, it goes with you.
- No use it or lose it! HHST schools that offer a Section 125 plan have allowed members to take advantage of flexible spending accounts for several years; unlike your FSA dollars, there is no use it or lose it rule with your HSA funds; balances rollover and continue to accumulate year after year.
- Triple tax advantage! An HSA offers a unique tax advantage that lets you keep more of your hard-earned dollars;

  (1) You can make pretax contributions so every dollar you contribute is a dollar saved; many schools offer payroll deduction for your HSA contribution, making it even easier to save!

  (2) Any gains on your HSA savings are tax free; you keep 100% of any money your savings or investments earn.

  (3) Withdrawals from your HSA are also tax free, as long as you use the money to cover expenses the IRS has approved for use to cover out-of-pocket medical expenses for you and your family. **NOTE:** at age 65, HSA dollars can be withdrawn and used as income *without a tax penalty*; however, it will still be subject to your normal income tax.
- You have control over your money. You decide how much to save (up to the IRS contribution limit) as well as what qualified expenses you will pay with your HSA dollars. You can also decide how to invest your money, and unused funds continue to grow year after year.

SEPT 2020 - AUG 2021	HDHP1 Network / Non	HDHP2 Network / Non
** Deductible – Single	$3,400 / $6,800	$6,000 / $12,000
** Deductible - Family	$6,750 / $13,500	$12,000 / $24,000
Co-Insurance %	0% / 30%	0% / 30%
OOP -Single	$5,000 / $10,000	$6,550 / $24,000
OOP – Family	$10,000 / $20,000	$13,100 / $48,000
Routine Care	100% (no ded) / 30%	100% (no ded) / 30%
Prescriptions	Deductible Applies, then Rx Copays	Deductible Applies, then Rx Copays

Many HHST schools will be holding informational meetings to help you learn more about the HDHP/HSA opportunity; check with your HR Department to see if there is a meeting scheduled for your school.

Do the Math - Is a HDHP/HSA the right choice for you?

* IRS eligibility guidelines apply to contributions into a Health Savings Account. If in doubt, please contact your financial advisor.
** Deductibles and out-of-pocket maximums accumulate on a calendar year, January – December.

RE Sutton & Associates
IRS Announces 2022 HSA Limits

May 2021

2022 HSA HIGHLIGHTS:

- HSA contribution limits have increased slightly. Self-only - $3,650 and family - $7,300.
- Minimum Deductibles remain unchanged.
- Maximum Out-of-Pocket Maximums have increased.
- Additional reimbursable expenses.

IMPORTANT DATES:

2022 HSA contributions may be made no earlier than January 1, 2022 and no later than the tax filing deadline for calendar year 2022.

The IRS has released the 2022 dollar limits for Health Savings Accounts (HSAs) and High Deductible Health Plans (HDHPs).

Calendar Year 2022	HSA Contribution Limit	Minimum HDHP Deductible	Minimum Embedded HDHP Deductible	HDHP Out-of-Pocket Maximum
Self-Only	$3,650	$1,400	$2,800	$7,050
Family	$7,300	$2,800	$2,800	$14,100
Catch-up contributions for those 55 or older	$1,000			

The Affordable Care Act (ACA) also applies an out-of-pocket maximum on expenditures for essential health benefits. These differ from the HDHP maximums. The IRS uses annual inflation increases, resulting in higher out-of-pocket maximums under the ACA.

The IRS recently announced additional qualified HDHP, FSA and HSA expenses. Effective January 1, 2020, HSA funds can be used to purchase certain over-the-counter medications and feminine hygiene products.

RE Sutton & ASSOCIATES Employee Benefit Consultants

Brown & Brown INSURANCE®

Important Notice from Hoosier Heartland School Trust
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 Hoosier Heartland School Trust 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. Hoosier Heartland School Trust has determined the prescription drug coverage offered by the Trust on PPO 1, PPO 2 and HDHP 1 as well as HDHP 2 is, on average, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable, you can keep this coverage and not pay a higher premium (penalty) if you later decide to join a Medicare drug plan. It has been determined HDHP 2, on average, is NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, this coverage is considered Non-Creditable Coverage. This is important because most likely, you will get more help with your drug cost of you join Medicare drug plan, than if you only have prescription drug coverage on HDHP 2. This is also important because it may mean that you may pay higher premium (penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from HDHP 2. 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 the coverage, depending on if and when you join the drug plan. When you make you 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.

If you lose your current creditable prescription drug coverage under PPO 1, PPO 2 or HDHP 1 through no fault of your own, you will also be 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?
You should also know that if you drop or lose your current coverage with the Trust health plan that includes prescription drug coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

Since the coverage under HDHP 2, 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 and still meet the eligibility for the Hoosier Heartland School Trust health plan, your current employee coverage will not be affected. You may continue your Hoosier Heartland School Trust employee coverage and elect part D and this plan will coordinate with Part D coverage.

Single	PPO 1	PPO 2	HDHP 1	HDHP2
			Combined Medical Deduct Applies - $3,400	Combined Medical Deduct Applies - $6,000
Tier 1	Greater of $12 or 20 % Max $50	Greater of $12 or 20 % Max $50	Greater of $12 or 20 % Max $50	Greater of $12 or 20 % Max $50
Tier 2	Greater of $25 or 20% max of $50	Greater of $25 or 20% max of $50	Greater of $25 or 20% max of $50	Greater of $25 or 20% max of $50
Tier 3	Greater of $50 or 20% max of $50	Greater of $50 or 20% max of $50	Greater of $50 or 20% max of $50	Greater of $50 or 20% max of $50
Tier 4	$100	$100	$100	$100
Rx Max out-of-pocket	$5,150	$3,650	Combined with Medical $5,000	Combined with Medical $6,550

If you do decide to join a Medicare drug plan and drop your current Hoosier Heartland School Trust coverage, be aware that you and your dependents may not be able to enroll in the Hoosier Heartland School Trust plan except during an open enrollment period or you experience a qualified HIPAA event.

For More Information About This Notice Or Your Current Prescription Drug Coverage, contact your Human Resource Department. NOTE:
You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if the coverage through the Trust changes. You may also 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).

August 1, 2021
Hoosier Heartland Trust
Trust Administrator
11595 N Meridian St, Ste 250
Carmel, IN 46032
(317) 574-5009

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

W E B R E S O U R C E S

HOOSIER HEARTLAND SCHOOL TRUST

mybensite.com/hoosier
Login: hoosier
Password: maessu

The Trust website contains a vast array of information about the Trust and benefits available to our members. You'll find benefit summaries, side-by-side comparison of the health plans, a prescription listing, customer service numbers, links to help you discover the benefits of opening a Health Savings Account, as well as other valuable resources.

United HealthCare

myuhc.com

We encourage you to register on the United HealthCare (UHC) website. You will gain access to your ID cards, be able to estimate your costs, find a provider, view your claims and much more. **Health4Me** is a mobile app that puts your health plan at your fingertips.

Telemedicine Options

First Stop Health **888-691-7867 or app2.fshealth.com**

Virtual Visits provides access to a doctor via the internet. They can diagnose and prescribe medications as needed. Consider downloading the app so it's availble when you might need it.

CVS/Caremark

caremark.com

Registering on the Caremark website is simple and provides you the ease of refilling your prescriptions online. You can also track how much you've spent and where you might have saving opportunities.

R E Sutton & ASSOCIATES Employee Benefit Consultants | Brown & Brown INSURANCE

UnitedHealthcare®

Welcome

Get the most out of your health plan.

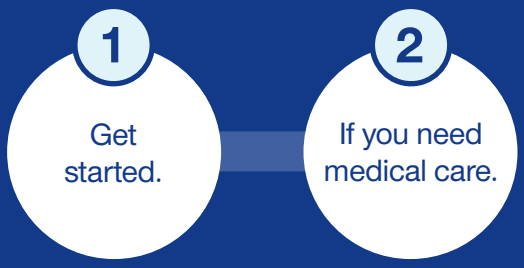
Here's how.

Let's do this.

Thank you for being a UnitedHealthcare member.

We're here to help make each step of your health care experience easier. This guide was designed to help you better understand your benefits, find care, manage costs and get more out of your health plan.

What's inside:



Call toll-free.

If you don't have computer access, need language assistance or still have questions after reading this, please call the toll-free member phone number on your health plan ID card, TTY **711**.*

Connect with us.

Facebook.com/UnitedHealthcare
Twitter.com/UHC
Instagram.com/UnitedHealthcare
YouTube.com/UnitedHealthcare

*A TTY is a special device that lets people who are deaf, hard of hearing or speech-impaired use the telephone to communicate by allowing them to type messages back and forth to one another.

1 Get started.

Activate your myuhc.com® account.

When it comes to managing your health plan, **myuhc.com** lets you see what's covered, manage costs and so much more. To help everyone get the most from their plan, it's important that each member age 18 and over create their own account. Then, use it to:

- Find a network doctor.
- View and pay claims.
- Check your account balances.
- Learn about preventive care.
- Find and estimate costs.
- Watch a personalized video about your plan's coverage and costs.*
- See a breakdown of your claim, showing how much your plan covered, what you owe and remaining out-of-pocket balances.

Set up your account today.

- Go to **myuhc.com > Register Now**.
- Have your ID card handy and follow the step-by-step instructions.

Download the UnitedHealthcare® app.

The UnitedHealthcare app puts your health plan at your fingertips. Download it to:

- Find nearby care options in your network.
- See your claim details and view progress toward your deductible.
- View and share your health plan ID card.
- Video chat with a doctor—without leaving the app.

Download on the App Store | GET IT ON Google Play

*Information will vary to reflect your actual coverage. Members with a Health Incentive Account are not eligible for the video.

Get started.

1 — 2

Simple ways to save.

Stay in the network.

The doctors and facilities in the network have agreed to provide services at a discount—so staying in network makes sense, especially when visiting an out-of-network provider could end up costing you a lot more for care. Sign in to **myuhc.com > Find Care & Costs** to locate:

- Labs
- Hospitals
- Mental health professionals
- Network doctors
- Pharmacies
- And more

Shop around.

With such a wide variety of services, from minor procedures to major surgeries, it's a good idea to check approximate pricing first. Visit **myuhc.com > Find Care & Costs** to estimate your costs. Members who comparison shop may save up to 36 percent* for care near them.

*UnitedHealthcare Internal Claims Analysis, 2015.

Know everything from your benefits to your balances.

Watch your personalized video for a quick and easier way to understand your coverage, out-of-pocket costs and how your plan* works. Watch (and re-watch) anytime by signing in to **myuhc.com > Coverage & Benefits.**

*Information will vary to reflect your actual coverage. Members with a Health Incentive Account are not eligible for the video.

2 If you need medical care.

How to get the most out of your benefits.

Pick a network PCP.

A PCP is a primary care provider, sometimes called a primary care physician or doctor. It can be a family practitioner, internist, pediatrician or general medicine physician. Although your plan may not require you to choose a PCP,* it's a good idea to have one. Your PCP generally:

- Knows your history.
- Builds an in-depth knowledge of your health over time.
- Helps guide you on the best path of care.
- Can advise you when to see a specialist and provide electronic referrals.

Find a network provider.

Sign in to **myuhc.com > Find Care & Costs** to find a network PCP, clinic, hospital or lab based on location, specialty, reputation, estimated cost of services, availability, hours of operation and more. You can even see patient ratings and compare quality and costs before you choose a provider. If you would like more information about a provider's qualifications, call the toll-free member phone number on your ID card.

Make more informed choices.

The **UnitedHealth Premium® Program** uses national, evidence-based, standardized measures to evaluate physicians in various specialties to help you locate quality and cost-efficient providers. Find UnitedHealth Premium Care Physicians by going to **myuhc.com > Find Care & Costs. Look for blue hearts.**

Keep up on preventive care.

Preventive care—such as routine wellness exams, certain recommended screenings and immunizations—is covered by most UnitedHealthcare plans at no additional cost when you see network providers. Learn more at **uhc.com/preventivecare.**

*Depending on your health plan, selection of a primary care physician may be required.

If you need medical care.

1 — 2

Know what to do if you need:

Referrals.

If your ID card states “Referrals Required,” you’ll need an electronic referral from your PCP before seeking services from another network provider. To learn what services require referrals, sign in at **myuhc.com > Coverage & Benefits** to view your coverage details.

Hospital care.

Talk to your PCP first to determine which hospital in your network can meet your medical or surgical needs. You or the admitting physician may be required to notify UnitedHealthcare before you’re admitted.

Prior authorization.

Your plan may also require prior authorization before you receive certain services. This means that you or your network provider may need to get approval from your plan before the services are covered. Call the toll-free member phone number on your ID card or sign in at **myuhc.com > Coverage & Benefits** to check if prior authorization is needed.

Here’s an example of how a health plan works.

Let’s take a look at an example of how a typical plan works when you receive care from a network provider. Your plan may be different. Find your specific plan details at **myuhc.com > Coverage & Benefits.**

And here’s the breakout.

At the start of your plan year... You’re responsible for paying 100 percent of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.	**YOU PAY 100%**
Along the way... You may also be required to pay a fixed amount—or **copay**—each time you see a provider.	**YOU PAY 100% of the copay**
Once you reach your deductible... Your health plan starts to share a percentage of the costs for covered health care services with you—this is your **coinsurance**.*	**YOU PAY 20%** **YOUR PLAN PAYS 80%**
When you reach your out-of-pocket limit... Your plan covers your costs (the allowed amount) at 100 percent. Your **out-of-pocket limit** is the most you’ll pay for covered health services in a plan year—copays and coinsurance count toward this.	**YOUR PLAN PAYS 100%**

*Your coinsurance may vary by service. This example is for illustrative purposes only. Please visit myuhc.com > Coverage & Benefits for your coverage details.

If you need medical care.

1 — 2

Get to know your care options and costs.

How much you pay for care can depend on where you go. You'll want to make your PCP your first stop whenever possible. For life-threatening conditions, call 911 or go to an emergency room.

Care Options	START HERE PCP Care from the doctor who knows you best.	Virtual Visits See a doctor whenever, wherever.	Convenience Care Basic conditions that aren't life-threatening.	Urgent Care Serious conditions that aren't life-threatening.	Emergency Room Life- and limb-threatening emergencies.
Average Cost*	**Varies by plan type**	**Less than $50****	**$90**	**$170**	**$2,000**
Hours	**Varies by location**	**24/7**	**Varies by location**	**Varies by location —may be open nights/weekends**	**24/7**
How to Connect	**Contact your PCP**	**myuhc.com/virtualvisits**	**myuhc.com**	**myuhc.com**	**myuhc.com**
✓ indicates the recommended place for care when it comes to the following common conditions:					
Broken bone				✓	✓
Chest pain					✓
Cough	✓	✓	✓		
Fever	✓	✓	✓		
Muscle strain	✓		✓		
Pinkeye	✓	✓	✓		
Shortness of breath					✓
Sinus problems	✓	✓	✓		
Sore throat	✓	✓	✓		
Sprain	✓		✓	✓	
Urinary tract infection	✓	✓	✓		

Did you know?

Emergency rooms are the most expensive place to get care. When you need to be seen, consider the chart above to help you find care. If you're still unsure about what's best for your situation, sign in to **myuhc.com > Find Care & Costs** to locate a network provider or call the member phone number on your ID card for support. If you have a question about what's covered by your plan, visit **myuhc.com > Coverage & Benefits** for answers.

*Source: 2017 Average allowed amounts charged by UnitedHealthcare Network Providers and not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. (Estimated $1,800.00 difference between the average emergency room visit and the average urgent care visit.) The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

Virtual Visits are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits and Urgent Care visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations.

**The Designated Virtual Visit Provider's reduced rate for a virtual visit is subject to change at any time.

Check your official health plan documents to see what services and providers are covered by your health plan.

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Mail: UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

Online: UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free member phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services:

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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

Phone: Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201

We provide free services to help you communicate with us such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

ATENCIÓN: Si habla español (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (**Vietnamese**), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (**Tagalog**), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русский (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني الخاص بك.

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (**French**), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (**Polish**), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (**Portuguese**), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.
ACHTUNG: Falls Sie Deutsch (**German**) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते है, आपको भाषा सहायता सेबाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

DÍÍ BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

Visit www.uhc.com/legal/required-state-notices to view important state required notices.

Member phone number services should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through the member phone number services are for informational purposes only and provided as part of your health plan. Wellness nurses, coaches and other representatives cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Please discuss with your doctor how the information provided is right for you. Your health information is kept confidential in accordance with the law. Member phone number services are not an insurance program and may be discontinued at any time.

Preventive care: Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (PPACA), based on your age and other health factors, with no cost-sharing. The preventive care services covered are those preventive services specified in PPACA. UnitedHealthcare also covers other routine services, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.

Evaluation of New Technologies: UnitedHealthcare's Medical Technology Assessment Committee reviews clinical evidence that impacts the determination of whether new technology and health services will be covered. The Medical Technology Assessment Committee is composed of Medical Directors with diverse specialties and subspecialties from throughout UnitedHealthcare and its affiliated companies, guest subject matter experts when required, and staff from various relevant areas within UnitedHealthcare. The Committee meets monthly to review published clinical evidence, information from government regulatory agencies and nationally accepted clinical position statements for new and existing medical technologies and treatments, to assist UnitedHealthcare in making informed coverage decisions.

For informational purposes only. Nurse, coach, and EAP services should not be used for emergency or urgent care situations. In an emergency, call 911 or go to the nearest emergency room. The nurse or coach service can't diagnose problems or recommend specific treatment. The information provided by the nurse, coach or EAP services are not a substitute for your doctor's care.

The UnitedHealth Premium® designation program is a resource for informational purposes only. Designations are displayed in UnitedHealthcare online physician directories at myuhc.com®. You should always visit myuhc.com for the most current information. **Premium designations are a guide to choosing a physician and may be used as one of many factors you consider when choosing a physician. If you already have a physician, you may also wish to confer with him or her for advice on selecting other physicians. You should also discuss designations with a physician before choosing him or her. Physician evaluations have a risk of error and should not be the sole basis for selecting a physician.** Please visit myuhc.com for detailed program information and methodologies.

The information in this guide is a general description of your coverage. It is not a contract and does not replace the official benefit coverage documents which may include a Summary of Benefits and Coverage and Certificate of Coverage/Summary Plan Description. If descriptions, percentages, and dollar amounts in this guide differ from what is in the official benefit coverage documents, the official benefits coverage documents prevail.

Twitter is a registered trademark of Twitter, Inc. Facebook is a registered trademark of Facebook, Inc. YouTube is a registered trademark of Google, Inc. Instagram is a registered trademark of Instagram, LLC.

The UnitedHealthcare® app is available for download for iPhone® or Android™.

Android is a registered trademark of Google LLC.

Google Play and the Google Play logo are registered trademarks of Google Inc.

Apple, App Store and the Apple logo are trademarks of Apple Inc., registered in the U.S. and other countries.

Virtual Visits and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Cost and Care section. Refer to your health plan coverage documents for information regarding your specific benefits.

Administrative services provided by United HealthCare Services, Inc. or their affiliates.

9684916.0 9/19 Standard ASO 19-13520-B

UnitedHealthcare®

Got your ID card? Let's get started.

Managing a health plan can be confusing, but here's where it gets easier.
The following 5 steps can help you take charge of your health and get more out of your plan.

1 Activate your myuhc.com® account.

Your personalized member website helps you manage your health plan, see what's covered and so much more. It can help you:

- Find network doctors.
- Find and estimate costs.
- View and pay claims.
- Check your account balances.
- Learn about covered preventive care.

2 Download the UnitedHealthcare® app.

Our app lets you take your plan and health plan ID card on the go. You can even find nearby care options in your network, video chat with a doctor 24/7 and check your progress toward your deductible.

Download on the App Store | GET IT ON Google Play

3 Stay in the network.

The doctors and facilities in our network have agreed to provide services at a discount — so staying in network makes sense, especially when visiting an out-of-network provider could cost you a lot more for care. You can find network doctors, mental health professionals, hospitals, labs and more at **myuhc.com > Find Care & Costs**.

4 Make your first appointment.

Many preventive screenings and immunizations are covered at no cost to you, so it's a good idea to call your primary care provider (PCP) and get your first checkup on the calendar.

5 Find out if you need prior authorization.

Your plan may require prior authorization before you receive certain services, tests or procedures. This means that you or your network provider may need to get approval from your plan before the services are covered. Prior authorization helps keep medical costs in check. Call the toll-free member phone number on your ID card or sign in at **myuhc.com > Coverage & Benefits** to check if prior authorization is needed.

Visit uhc.com/memberresources to learn more.

UnitedHealthcare®

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. UnitedHealthcare also covers other routine services, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

Virtual Visits and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Care & Costs section.

The UnitedHealthcare® app is available for download for iPhone® or Android™. iPhone is a registered trademark of Apple, Inc. Android is a trademark of Google LLC. Apple, App Store and the Apple logo are trademarks of Apple Inc., registered in the U.S. and other countries. Google Play and the Google Play logo are registered trademarks of Google Inc.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

Who is RxBenefits?

RxBenefits is your Pharmacy Benefit Optimizer (PBO).

- We partner with the country's largest Pharmacy Benefit Managers (PBMs) to bring greater discounts, enhanced access, and improved Member Services Welcome Team to our clients and their employees.
- ***Your pharmacy benefits coverage will be with CVS/caremark.***

How Can We Help?

You have access to our ***Member Services***, available Monday through Friday, 7:00 a.m. – 8:00 p.m. Central. Our knowledgeable representatives can assist you with questions such as:

NOTE: Your benefits are still being provided by CVS/caremark, but **RxBenefits** administers the services for a more personal and manageable approach. You should contact **RxBenefits at 800.334.8134** with any pharmacy-related questions.

What to Expect

- Effective 9/01/2021, your pharmacy coverage will continue with CVS/caremark, administered by **RxBenefits**
- As part of your pharmacy benefits plan, you will receive:
  - *Friendly, high-touch service from RxBenefits' professional Member Services Team*
  - *Commitment to issue resolution*
  - *Access to **caremark.com** to review medication tiers, drug pricing, local pharmacies, plan details and ways to maximize benefits. New members will need to create an account.*

There are more than 68,000 pharmacies in the CVS/caremark network, including most national chains and many independent stores

For questions or concerns, members can contact RxBenefits' Member Services Team

800.334.8134

Monday through Friday
7:00 a.m. – 8:00 p.m. Central

CustomerCare@RxBenefits.com

Your Plan Details – PPO (Plan 1)

Maximum Out of Pocket (MOOP): $5,150 individual/$10,300 family

Tier	1-30 Day Supply Retail	90-Day Supply Mail	90-Day Supply Retail
Generic/Tier 1	$12 or 20%	$24 or 20%	$24 or 20%
Preferred Brand/Tier 2	$25 or 20%	$50 or 20%	$50 or 20%
Non-Preferred Brand/Tier 3	$50 or 20%	$100 or 20%	$100 or 20%
Specialty Medications	$12/$25/$50 or 20%	N/A	N/A

NOTE:

Some medications could require a prior authorization or have a limited quantity. If you have an existing authorization in place, you will not need to get a new authorization.

Drugs that fall under the Affordable Care Act are covered at 100%
*Deductible waived for preventive drugs, however, copays will apply

Your Plan Details – PPO (Plan 2)

Maximum Out of Pocket (MOOP): $3,650 individual/$7,300 family

Tier	1-30 Day Supply Retail	90-Day Supply Mail	90-Day Supply Retail
Generic/Tier 1	$12 or 20%	$24 or 20%	$24 or 20%
Preferred Brand/Tier 2	$25 or 20%	$50 or 20%	$50 or 20%
Non-Preferred Brand/Tier 3	$50 or 20%	$100 or 20%	$100 or 20%
Specialty Medications	$12/$25/$50 or 20%	N/A	N/A

NOTE:

Some medications could require a prior authorization or have a limited quantity. If you have an existing authorization in place, you will not need to get a new authorization.

Drugs that fall under the Affordable Care Act are covered at 100%
*Deductible waived for preventive drugs, however, copays will apply

Your Plan Details – HDHP (Plan 1)

Deductible: $3,400 individual/$6,750 family

Maximum Out of Pocket (MOOP): $5,000 individual/$10,000 family

Tier	1-30 Day Supply Retail	90-Day Supply Mail	90-Day Supply Retail
Generic/Tier 1	$12 or 20%	$24 or 20%	$24 or 20%
Preferred Brand/Tier 2	$25 or 20%	$50 or 20%	$50 or 20%
Non-Preferred Brand/Tier 3	$50 or 20%	$100 or 20%	$100 or 20%
Specialty Medications	$12/$25/$50 or 20%	N/A	N/A

NOTE:

Some medications could require a prior authorization or have a limited quantity. If you have an existing authorization in place, you will not need to get a new authorization.

Drugs that fall under the Affordable Care Act are covered at 100%
*Deductible waived for preventive drugs, however, copays will apply

Your Plan Details – HDHP (Plan 2)

Deductible: $6,000 individual/$12,000 family

Maximum Out of Pocket (MOOP): $6,550 individual/$13,100 family

Tier	1-30 Day Supply Retail	90-Day Supply Mail	90-Day Supply Retail
Generic/Tier 1	$12 or 20%	$24 or 20%	$24 or 20%
Preferred Brand/Tier 2	$25 or 20%	$50 or 20%	$50 or 20%
Non-Preferred Brand/Tier 3	$50 or 20%	$100 or 20%	$100 or 20%
Specialty Medications	$12/$25/$50 or 20%	N/A	N/A

NOTE:

Some medications could require a prior authorization or have a limited quantity. If you have an existing authorization in place, you will not need to get a new authorization.

Drugs that fall under the Affordable Care Act are covered at 100%
*Deductible waived for preventive drugs, however, copays will apply

Specialty Medications

Specialty medications are covered when purchased through CVS Specialty Pharmacy

*CVS Specialty Pharmacy can be contacted at **800.318.6108***
Members can also contact the RxBenefits Member Services team for assistance.

The CVS/caremark App

Now on the CVS/caremark mobile app it's more convenient than ever to view and refill all your mail, retail, and specialty prescriptions from one place with the new Integrated Pharmacy App Experience.

Easy Refills - Refill all your mail orders and specialty prescriptions in one place

Manage and Track – View all your orders in one easy-to-manage list and track the status for all your prescriptions

Flexible Pick Up and Delivery – Transfer all your prescriptions to CVS/caremark or choose to pick up at a CVS pharmacy

View Prescription Spend – See total costs for yourself and your family in one view to make budgeting easier

Visit caremark.com or Download the CVS/caremark mobile app today to refill all your prescriptions.

GET IT ON Google play

Download on the App Store

Frequently Asked Questions

Q: Are my drugs covered?

A: You can access a copy of the most current Preferred Drug List at www.caremark.com or by contacting RxBenefits Member Services Team at **800.334.8134**. Formularies change, so your medications may not be in the same tier level as last year, so please review the preferred drug list since it may provide lower cost alternatives for your medications. Also, discussing generics with your physician could save you money.

Q: If my coverage is with CVS/caremark, why do I need to call RxBenefits?

A: Your benefits are being provided by CVS/caremark, but RxBenefits administers the services for a more personal, manageable approach. You should contact RxBenefits for any pharmacy-related questions***.***

Q: What happens if my questions require contact with CVS/caremark?

A: RxBenefits' Member Services Team reps have access to the CVS/caremark systems. If RxBenefits needs to contact CVS/caremark to resolve an issue, they will stay on the line, explain the issue, and continue to monitor your problem until it is resolved.

For questions or concerns, members can contact RxBenefits' Member Services Team

800.334.8134

Monday through Friday

7:00 a.m. – 8:00 p.m. Central

CustomerCare@RxBenefits.com

Questions?

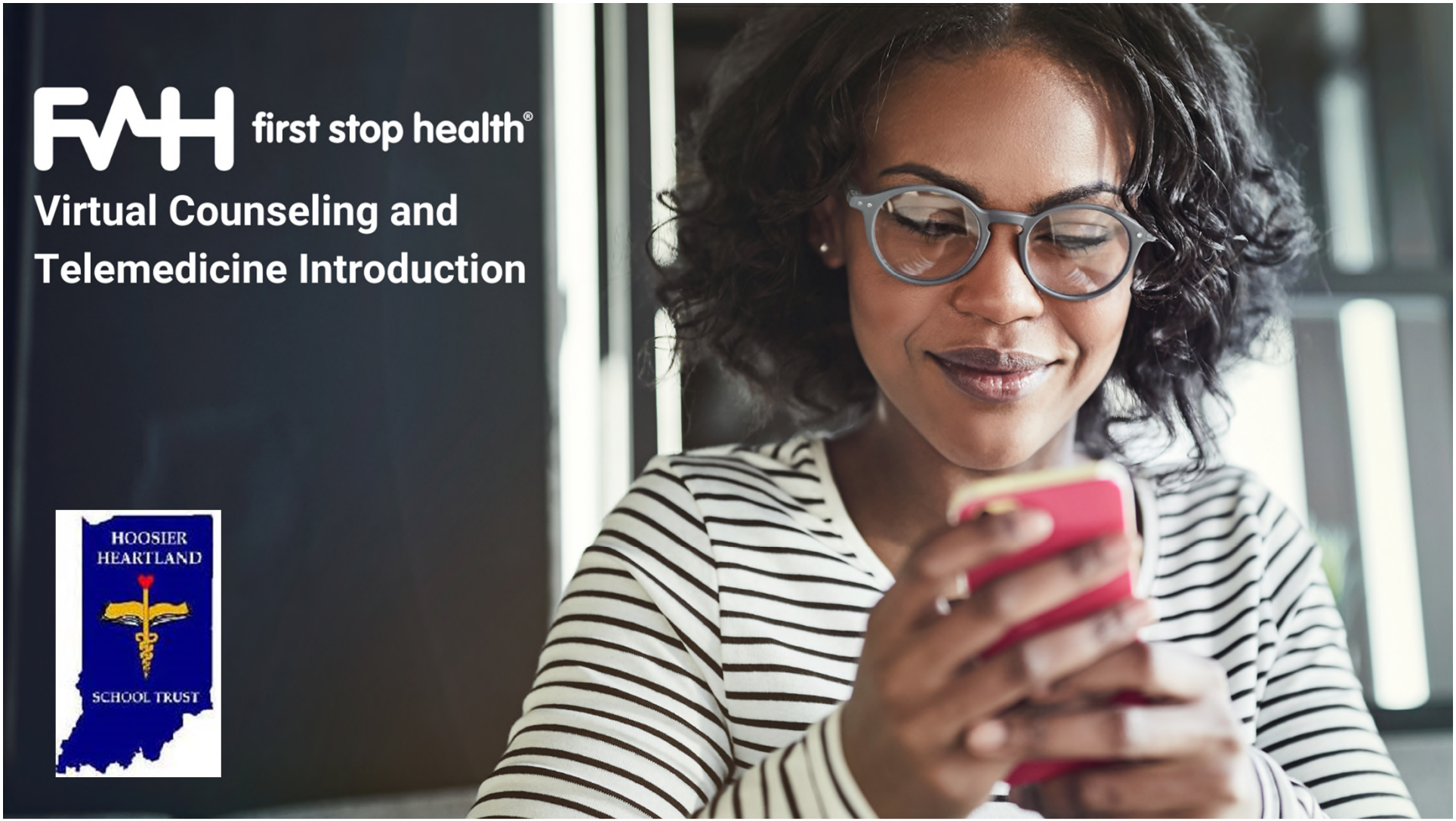
Member Services

800.334.8134

CustomerCare@RxBenefits.com

RxBenefits' Welcome Team is available Monday through Friday, 7:00 a.m. – 8:00 p.m. Central.

On weekends, holidays, and after-hours, members are given the option to speak with a CVS representative or leave a message for us to return their call.


first stop health®
Virtual Counseling and
Telemedicine Introduction
HOOSIER
HEARTLAND
SCHOOL TRUST

About Your Benefits

Telemedicine and Virtual Mental Health Solution

Confidential diagnosis and treatment are provided conveniently via **phone and video.**

Get connected to a doctor or counselor in **MINUTES**! Available at any time, **24/7**.

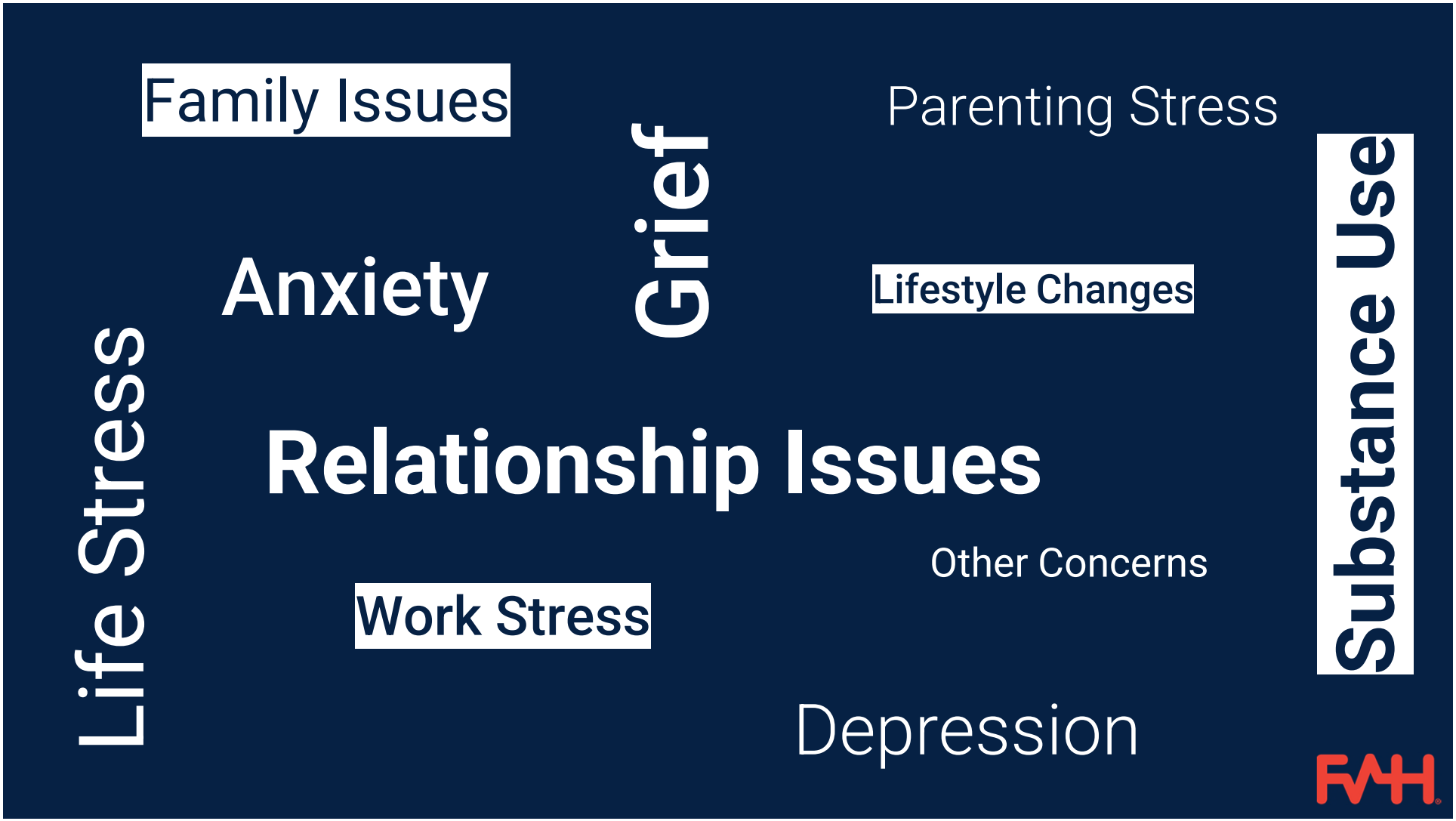
Easy to use mobile app! Get help at home, work, or when traveling.

When appropriate, a doctor may prescribe a **medication**.

Doctors and counselors licensed in **50 states**. Use FSH from home, work, or when traveling.

No cost to medical-enrolled employees or their covered dependents!


65%
of consultations result in a prescription
Sore Throat
Skin Rash / Injury / Infection
Other Medical Question
Stomach Pain/Issue
Other Skin Issue
Urinary Tract Infection
Pink Eye
Other Eye Issue
Flu
Sinus Issue
Tooth Ache
Rx Refill
Body Injury or Pain
Yeast Infection
Ear Ache
Cold Sore / Herpes
Allergies
Medication Question
Cough
Other Gynecologic Issue


Family Issues
Parenting Stress
Grief
Substance Use
Anxiety
Lifestyle Changes
Life Stress
Relationship Issues
Other Concerns
Work Stress
Depression

Not sure if it can be treated?

- Err on the side of care!
- Request a visit to ask medical questions to a certified doctor.
- Doctors can advise on next steps for your medical concern.

Using First Stop Health

Patient Experience

Request

Request a doctor or counselor visit via app, web or phone.

Intake

Answer questions about why you'd like to speak to a doctor or counselor, as well as any personal information.

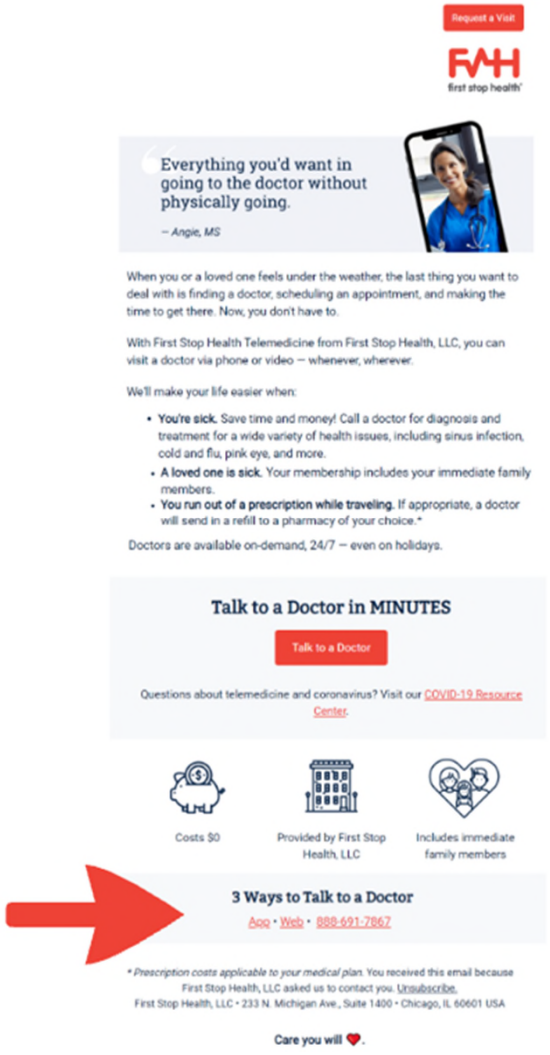
Visit

Doctors will call in < 5 minutes (on average), and a counselor will call at the chosen appointment time.

Follow Up

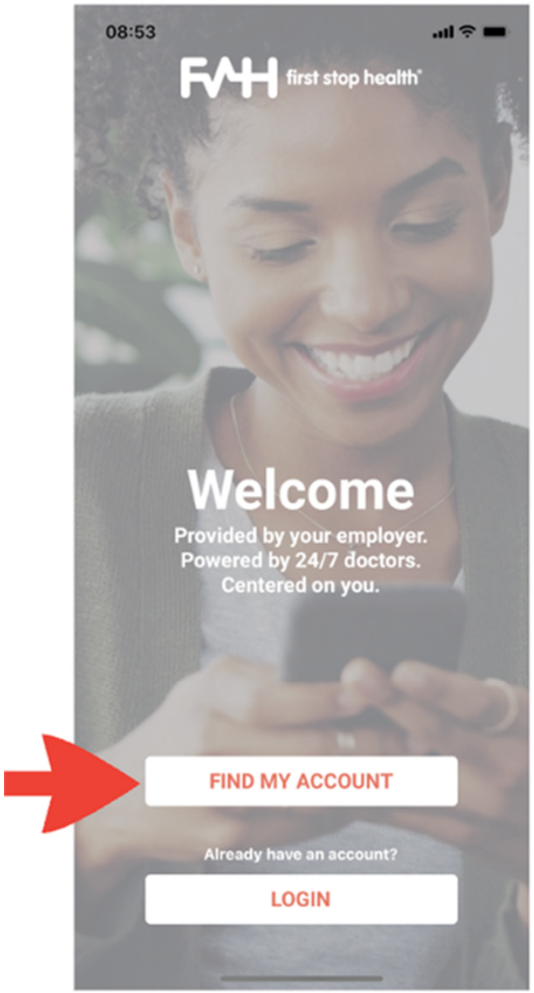
After your visit, you can access your sick note, Rx, doctor instructions, and rate your visit on the app.

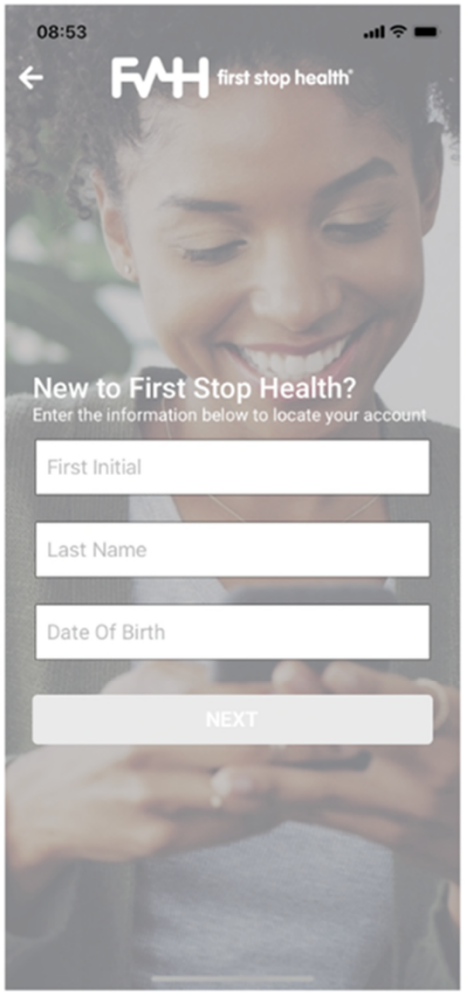
Claim Your Account



Access your account through:

- Welcome email buttons
- Going to fshealth.com
- Downloading the app





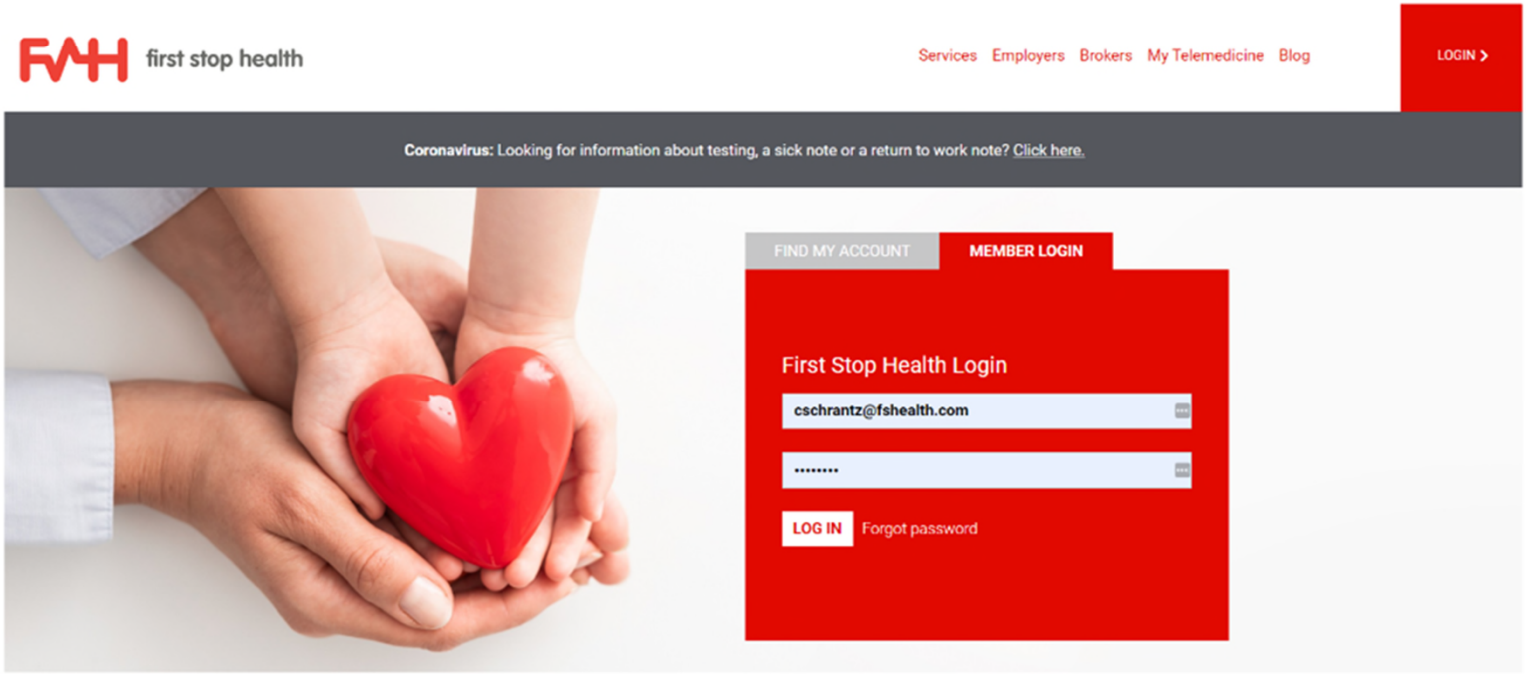
GET IT ON Google Play

Download on the App Store

Verify account and create a login with credentials:

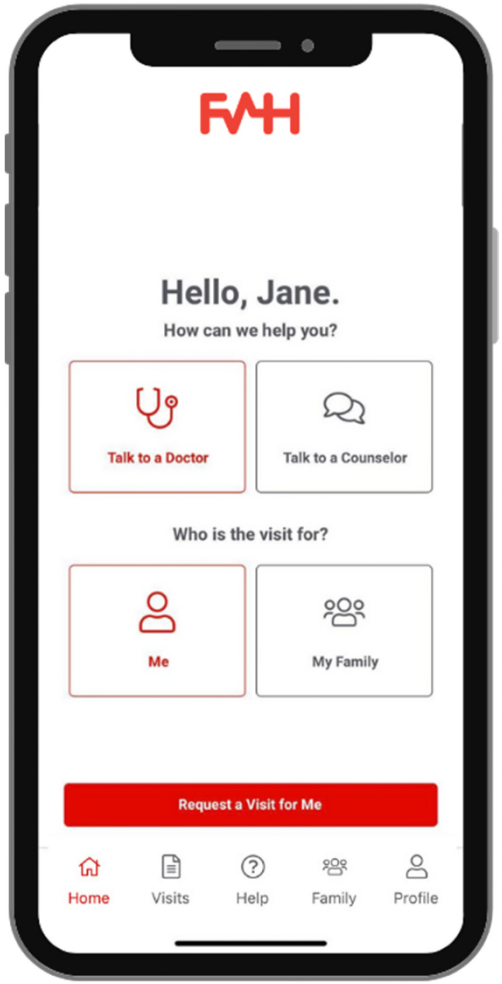
- Name
- Date of Birth
- Last 4 digits of SSN

Go to www.fshealth.com
Click 'Find my Account' to login for the first time
For returning users, click 'Member Login'



Don't hesitate to contact us with questions about logging in!

3 Ways to Request a Visit

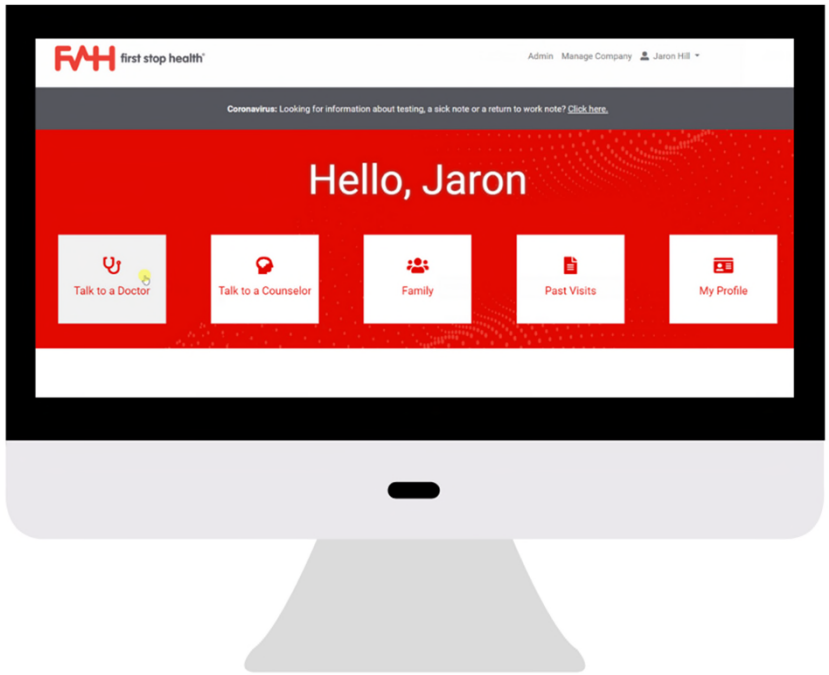


Mobile App

With the app, you can:

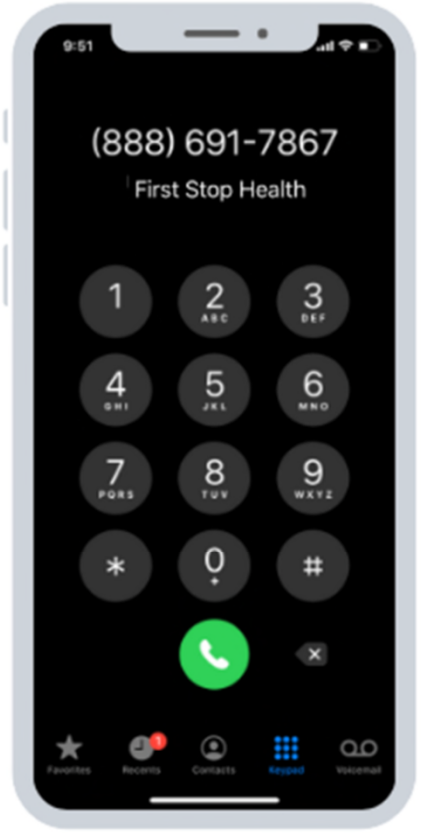
- Request a telemedicine or counseling visit
- Add and manage family members
- Update preferences and information
- Contact FSH
- Rate your visit
- View doctor visit information
  - Listen to past visits
  - Review doctor instructions
  - Download your sick note

Dashboard



Same features as on app!

Just Call!



Call 888-691-7867

Save our number now!

Intake - Visit - Follow Up

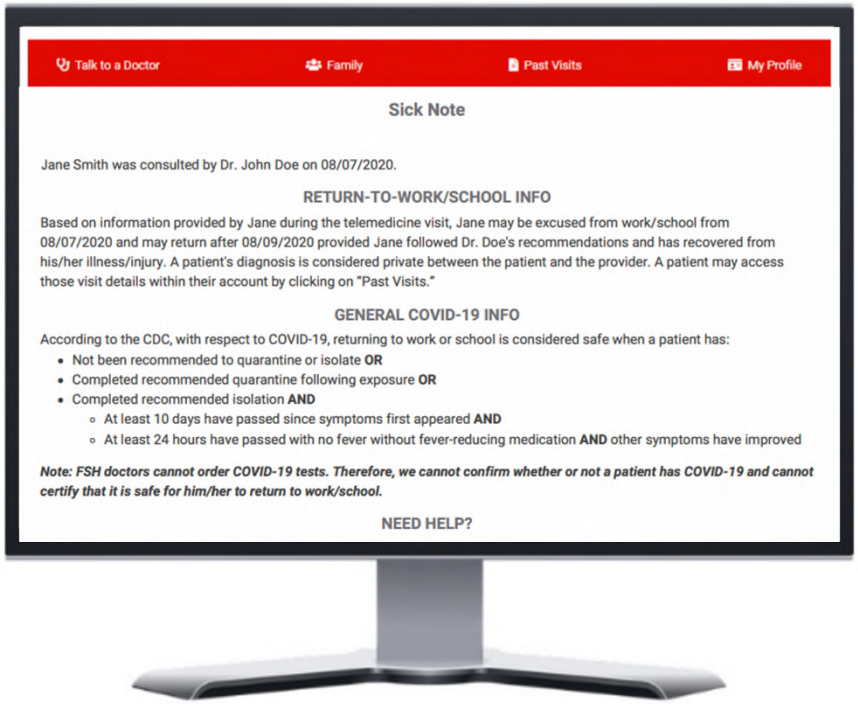
Intake & Visit Process

1. **Log into App or Web**
   (You can also just call)
2. **Select “Talk to a Doctor” or “Talk to a Counselor”**
3. **Select Primary Symptom or Concern**
4. **Provide Medical Info, Current State, and Visit Type**
5. **Confirm Contact Info**
6. **Receive doctor call or schedule counseling appointment**

After Your Visit

- Through the app or website, you can find:
  - Instructions from your doctor
  - A recording of your visit
  - A sick note, if you requested one during your visit
  - Which pharmacy you selected to use
  - What medication you were prescribed (if any)
- Obtaining your prescription:
  - Your prescription should take < 30 minutes to be filled
  - Prescription costs are not covered by First Stop Health

Sick Note



Patients may request a sick note during intake.

Sick notes can be downloaded from the mobile app or dashboard following the visit.

Patients may receive up to 4 days* per illness and 10 days in any 12-month period.

** Can be extended to 14 days for COVID-19 related symptoms*

Patient FAQs

How much does it cost?

Both virtual counseling and telemedicine appointments are FREE!

Prescriptions are available when appropriate; costs applicable to your medical plan.

Who can use this service?

Telemedicine and counseling services are provided to medical-enrolled employees and their covered dependents.

Who will I be speaking to?

Doctors are licensed in all 50 states and are board certified.

Licensed, experienced counselors hold masters-level degrees or higher and are available nationwide.

How long will it take to speak to a doctor?

For telemedicine, a doctor will call within a few minutes of requesting an appointment.

For virtual counseling, an operator will call immediately. They will help you to schedule an appointment with a counselor in your related area of concern.

Can I use this when I’m traveling?

Yes! You can use First Stop Health from all 50 states.

Will I get anything from First Stop Health?

Yes! If you have a valid address on file with your employer, you will receive a welcome letter about one month after your membership start date.

If you have a valid email address on file with your employer, you will receive periodic monthly emails.

Need help troubleshooting?

For pharmacy questions, issues logging in, and any help you may need, our team is available.

- **App**: Click the “Help” tab
- **Call**: 888-691-7867 and press 2
- **Email**: member_services@fshealth.com

Watch the 1-minute overview videos!

Talk to a Doctor
https://youtu.be/y-gMYDdQxSE

Talk to a Counselor
https://youtu.be/Gc62jgrC-4w

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____

.

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.

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[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

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:

- With respect to dependents:

☐ We do offer coverage. Eligible dependents are:

☐ 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

IMPORTANT ANNOUNCEMENT FOR EMPLOYEES and RETIREES

This notice is to advise you of how you can access current Plan summaries that outline all benefit options available to employees, retirees or dependents that are *currently eligible* for coverage, or *may become eligible* in the future. Coverage is provided by the Hoosier Heartland School Trust.

A Summary of Benefits and Coverage (SBC) for each plan choice is posted to the Trust website and is available for your viewing at www.mybensite.com/hoosier.

The SBCs are compliant with federal PPACA format and content requirements.

A printed copy of the SBC will be provided to you *free of charge* upon request. Contact the Benefit Coordinator at your school if you would like to receive a printed copy, or to confirm your eligibility to enroll.

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 January 31, 2020. Contact your State for more information on eligibility –

INDIANA – Medicaid	
Healthy Indiana Plan for low-income adults 19-64	Website: http://www.in.gov/fssa/hip/ or 1-877-438-4479
All other Medicaid	Website: http://www.indianamedicaid.com or 1-800-403-0864

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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.

OMB Control Number 1210-0137 (expires 1/31/2023)

WOMEN'S HEALTH AND CANCER RIGHTS ACT 0F 1998 ANNUAL NOTICE

The HHST group health plan, as required by the Women's' Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services. These include but are not limited to all stages of reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy, including lymphedema. If you have questions or need more information, contact your Plan Administrator at the phone number on the back of your United Healthcare ID card.

NOTICE OF PRIVACY PRACTICES
HOOSIER HEARTLAND SCHOOL TRUST HEALTH PLANS

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.

The Hoosier Heartland School Trust maintains group health plans, including Medical and Prescription Drug (collectively, the "Plan"), that are required to comply with a new federal regulation governing health privacy. This new regulation, commonly referred to as the HIPAA Health Privacy Rule, imposes significant restrictions upon the Plan and provides participants with extensive rights. The Plan is required to provide you with the following information in connection with the new federal regulation.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The Plan may use and disclose information that relates to your physical or mental health, your receipt of health care services, or payment information relating to your health care. This information may either identify you or could reasonably be used to identify you. Use and disclosure of this information is permissible **only** to the extent provided by the Health Privacy Rule.

It will be necessary for the Plan to obtain an Authorization from you if the Plan intends to use or disclose your health information and the use or disclosure is not permitted or required by the Health Privacy Rule. It will not be necessary for the Plan to obtain an Authorization in the following situations:

1. Treatment: The Plan may use or disclose your protected health information to assist in your treatment. For example, the Plan may provide your information to a physician who is taking care of you if you suffer an injury or illness. The Plan may also provide this information in limited circumstances to members of your family to the extent the information is directly relevant to his or her involvement in your medical care.

2. Payment: The Plan may use or disclose your protected health information to assist in payment for health care services. For example, the Plan may use this information to determine your eligibility or coverage under the Plan and in the process of reviewing your health benefit claims. However, the Plan is generally prohibited by Indiana state law from requesting or using genetic information about you with respect to any decision by the Plan involving coverage or benefits. The Plan may also use your protected health information in connection with risk adjustments, billing and collection activities, obtaining payment under a contract for reinsurance (including stop-loss

insurance and excess loss insurance) and utilization review activities. The Plan also retains the right to use this information to review health care services for medical necessity, coverage, justification of charges and similar activities.

3. Health Care Operations: The Plan may use or disclose your protected health information to assist in Plan operations. For example, the Plan may use this information to conduct quality assessment and improvement activities or to review health plan performance. In addition, the information may be used for underwriting and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims. The Plan may conduct or arrange for medical review, legal and auditing services, including fraud and abuse detection and compliance programs. In addition, protected health information may be used for business planning and development, such as conducting cost-management and planning analyses relating to managing and operating the entity. Finally, the Plan may use the information for business management and general administrative activities, including those related to implementing and complying with the Health Privacy Rule, customer service, resolution of internal grievances, sale or transfer of assets, creating de-identified information or a limited data set.

4. As Required by Law: The Plan may use or disclose your protected health information as required by law.

5. Public Health Risks: The Plan may disclose your protected health information for certain public health activities. Such disclosures may be necessary to prevent or control disease, injury or disability.

6. Situations of Abuse: The Plan may disclose your protected health information in certain instances of abuse, neglect or domestic violence.

7. Law Enforcement: The Plan may disclose your protected health information to law enforcement officials for law enforcement purposes in certain circumstances.

8. Disaster Relief Efforts: The Plan may disclose your protected health information to a public or private entity authorized by law or its charter to assist in disaster relief efforts to the extent the information is used for notification purposes.

9. Coroners, Medical Examiners and Funeral Directors: The Plan may disclose your protected health information to coroners, medical examiners and funeral directors to assist them in carrying out their duties.

10. Organ and Tissue Donation: The Plan may disclose your protected health information if you are an organ or tissue donor to the extent necessary to facilitate the organ or tissue donation and transplantation.

11. Public Safety: The Plan may disclose your protected health information to the extent necessary to prevent a serious and imminent threat to the health or safety of a person or the public.

12. Government Activities: The Plan may disclose your protected health information for specialized government functions, including military activities, national security and intelligence activities.

13. Workers' Compensation: The Plan may disclose your protected health information to the extent necessary to comply with workers' compensation or other similar programs that provide benefits for work-related injuries or illness without regard to fault.

14. Inmates: If you are an inmate of a correctional institution or are otherwise under the custody of law enforcement, the Plan may disclose your protected health information to the correctional institution or law enforcement body.

15. Marketing: In very limited circumstances set forth in the Health Privacy Rule, the Plan use or disclose your protected health information during a face-to-face encounter with you or in connection with a promotional gift of nominal value.

Except as provided above or otherwise permitted by the Health Privacy Rule, the Plan may use and disclose your protected health information **only** upon your written Authorization. You may generally revoke an Authorization at any time unless the Plan: (i) has taken action in reliance upon the Authorization; or (ii) in certain instances, if the Authorization was obtained as a condition of obtaining insurance coverage.

YOUR LEGAL RIGHTS

You have the following rights with respect to protected health information that we maintain about you:

1. You have the right to request restrictions on certain uses and disclosures of your health information to carry out treatment, payment or health care operations. You may also request restrictions on uses and disclosures of your information to family members, relatives and close personal friends who are involved with your care or payment for your health services. The Plan is not required to agree to these requested restrictions.

2. You have the right to receive confidential communications of your protected health information. Specifically, you may request to receive communications by alternative means or at alternative locations. Your request will be honored only if you submit a written request to the Privacy Official that states that disclosure of all or a portion of your protected health information would endanger you.

3. You have the right to inspect and copy your protected health information. Should you wish to exercise this right, please provide a written request to the Privacy Official. Generally, the Plan is required to respond within 30 days of your request. If the Plan grants the request, it must generally provide you with access to your information in the form or format that you request. The Plan may impose reasonable, cost-based fees if you request a copy of your information.

4. You have the right to amend your protected health information. You must request such amendment in writing and you must provide a reason to support the requested amendment. The Plan must generally act upon your request within sixty days. The Plan may deny your request for the reasons set forth in the Health Privacy Rule.

5. You have the right to receive an accounting of disclosures of your health information to the extent provided in the Health Privacy Rule. Please submit any request for an accounting in writing to the Privacy Official. The Plan must generally respond to your request within 60 days. In the event that the request is granted, the Plan will provide a record of disclosures of protected health information made by the Plan during the previous six-year period (or any lesser period requested). The accounting will not include disclosures made before the Effective Date of this Notice. The accounting will provide the date of each disclosure and a brief description of the purpose of the disclosure. In the event that the Plan has made multiple disclosures to the same person or entity for a single purpose, the Plan is only required to provide detailed information with respect to the first disclosure.

6. You have the right to obtain a paper copy of this Notice from the Plan upon request, even if you have previously agreed to receive the Notice electronically.

DUTIES OF THE PLAN

The Health Privacy Rule requires the Plan to comply with the following duties and obligations.

1. The Plan is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.

2. The Plan is required to abide by the terms of its Notice currently in effect.

3. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information maintained by the Plan. You will receive a revised Notice by mail unless you have previously agreed to receive the Notice electronically.

4. The Plan does not currently maintain a website. In the event that one is established, a copy of this Notice will be posted to the website.

5. You may complain to the Plan and to the Secretary of Human Services if you believe that your privacy rights have been violated. **YOU WILL NOT BE RETALIATED AGAINST FOR FILING A COMPLAINT.** You may submit a complaint in writing by (a) delivering it personally; (b) registered or certified mail, return receipt requested, postage prepaid; (c) prepaid overnight courier. The complaint should be submitted to:

Privacy Official
Hoosier Heartland School Trust
11595 N Meridian St, Ste 250
Carmel, IN 46032

6. If you have any questions or concerns about the Plan or your legal rights under federal law, you may contact:

Privacy Official
Hoosier Heartland School Trust
11595 N Meridian St, Ste 250
Carmel, IN 46032

7. This Notice shall be effective on April 14, 2004. Once effective, this Notice will remain in effect until a new Notice is issued.

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