DISCOVER YOUR BENEFITS

2026 OPEN ENROLLMENT GUIDE

OPEN ENROLLMENT

You play an imperative part in the plans victory. That's why every attempt has been made to make available the best benefits program that compensates you for the hard work you put forth. Benefits are an important part of your total compensation package. This guide provides information to help you better understand your health plan and benefits.

During the open enrollment period you have the chance to review your needs, review the benefits available to you and make selections that are most valuable to you. Open enrollment is your chance to make changes to your benefit enrollments.

If after reading the information in this guide you have any additional questions, please contact Dunn & Associates or Stephanie Bolling.

Online enrollment will be open October 6, to October 10, 2025.
Please complete your enrollment by October 10, 2025.

The benefits you choose during this time will be effective **January 1, 2026**.

If you would like to continue with your current elections no action is required.

Note: you may also change your coverage during the year if you have a qualifying event. This includes but is not limited to loss of coverage, death, marriage, birth, divorce, or adoption. For any allowable change you must notify your Employer/Group Health Plan within 30 calendar days of the event and provide proof of the event, or you must wait until the next open enrollment to make changes.

ELIGIBILITY

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

Eligible dependents include:

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

Waiting Period: 1st of the month following employment for this Employer.

Working Spouse Rule: If the spouse of the Employee is employed and eligible for coverage under their own employer (regardless of cost) that spouse will NOT be eligible for coverage through this plan.

CONTACT INFORMATION

Employer	**SE Dubois Schools** Stephanie Boling	(812) 817-0900 Ext 9002	sboling@sedubois.k12.in.us
Medical Benefits	**Dunn & Associates** Claims – Renada Pyatt Eligibility	(800) 880-9960	rpyatt@dunnbenefit.com claimsdept@dunnbenefit.com eligibility@dunnbenefit.com
Pharmacy Benefit Manager	**TrueRx**	(866) 921-4047	www.truerx.com RxBin 020958 RxPCN 0796000 RxGrp TRUE1580
Precertification	**Clinix**	(800) 227-2298	www.clinix.com
PPO	**Patoka Valley Health Care Cooperative**	(800) 318-1590	www.pvcooperative.com
	United Health Care	(888) 830-0179	https://uhss.umr.com
Telemedicine	**Revive Health** (previously SwiftMD)	(833) 794-3863	www.swiftmd.com Passcode: SEDUBOIS17
International Prescription Drug Mail Order program	**CanaRx**	(866) 893-6337	www.canarx.com *Separate information available through HR.*

Dunn Online:

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

BENEFIT SUMMARY

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

No Changes for 2026!

MEDICAL	In-Network	Out-of-Network
Deductible Single/Family	$3,500/$7,000	$7,000/$14,000
Coinsurance Limit - Medical Single/Family	$3,500/$7,000	$7,000/$14,000
Coinsurance Limit - Rx Single/Family	$0/$0	$0/$0
Out of Pocket Maximum Single/Family	$7,000/$14,000	$14,000/$28,000
Covered Expenses	Plan pays 90% after deductible	Plan pays 70% after deductible
Preventative Care	Plan pays 100% no deductible	Plan pays 70% after deductible
Office Visit (Primary Care)	Plan pays 90% after deductible	Plan pays 70% after deductible
Urgent Care	Plan pays 90% after deductible	Plan pays 70% after deductible
Emergency Care	Plan pays 90% after deductible	Plan pays 90% after deductible

BENEFIT SUMMARY – PRESCRIPTION DRUG BENEFIT

PRESCRIPTION DRUGS	Retail (30-day supply)	Mail Order (90-day supply)
Generic Brand Non-Brand	0% after deductible 0% after deductible 0% after deductible	0% after deductible 0% after deductible 0% after deductible
Specialty Rx Tier 1 Tier 2 Tier 3 Tier 4	0% after deductible 0% after deductible 0% after deductible 0% after deductible	
Specialty drugs will no longer be covered under this plan if the patient qualifies for patient assistance from the drug manufacturer or any other available assistance plan. If the patient does not qualify for assistance, coverage will be available under this plan. TrueRx will provide guidance and instruction for the patient to assist with the qualification process.		

BENEFIT SUMMARY – WELLNESS

WELLNESS BENEFIT	
Health Screening & Risk Assessment Covered employee/spouse	$25 each
Fitness Program Participant Minimum participation 10 sessions per month. Includes gym, fitness center, group exercise class, personal training by a certified instructor.	$25 per month $250 annual maximum
Fitness Activity (Example: Marathon, Half-Marathon, Walks)	$15 per activity
Self-Reported Activities Minimum participation 10 sessions per month. Includes activities such as running, walking, swimming and biking. Track and report your statistics. Example: How long did you walk? How many steps did you take? How many miles did you run?	$15 per month $150 annual maximum

HOW THE PLAN WORKS!

Credits earned in 2026 will be deposited into your Health Savings Account (HSA) in quarterly to avoid going over the annual maximum each year. When an event is completed fill out the Wellness Benefit form, attach proof of participation and submit the information to Dunn & Associates.

NOTE:

- ✓ Eligible expenses include amounts applied to deductibles, copays and coinsurance through your HSA.
- ✓ HSA money may accumulate and roll over from year to year if not used!

Fax: (812) 378-9967
Email: Finance Department financedept@dunnbenefit.com

The wellness program is not available to Retirees.

WELLNESS NOTICE

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

Protections from Disclosure of Medical Information

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

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

Quest Diagnostics®

QuestSelect™ Plus lab benefit

Control the cost of your healthcare

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

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

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

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

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

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

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

Saving with QuestSelect™ is simple

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

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

Frequently asked questions

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

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

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

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

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

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

Q. What tests are NOT covered under QuestSelect?
A - QuestSelect™ does not cover:

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

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

For a complete list of Frequently Asked Questions, please visit QuestSelect.com.

Quest, Quest Diagnostics, any associated logos, and all associated Quest Diagnostics registered or unregistered trademarks are the property of Quest Diagnostics. All third-party marks—® and ™—are the property of their respective owners. © 2022 Quest Diagnostics Incorporated. All rights reserved. QS0004 06/22

Lab Program – Other Options

There are some other preferred lab options (not required) you can explore. These options may depend on where you live and travel time. Visit the website to determine the closest location to you. Benefits are 100% after deductible.

Alverno Labs –www.alvernolabs.com

LabCorp - https://www.labcorp.com/patients

Dubois County Health Department
1187 S St. Charles St. Jasper, IN 47546
(812) 481-7050

Mon to Fri 8AM to 2PM
**must be 18 years or older*

Pharmacy Benefit Manager

See separate TrueRx Packet.

CANARX is a voluntary international mail order option. To be eligible for the CANARX program, you must be an existing member of a health insurance plan that currently has CANARX implemented as an additional option for prescription medication coverage.

FREE Brand-Name Medications

No Shipping and Handling Charges to You!

ZERO COPAYS

Who is CANARX?

SIMPLE.

We're the easy way for you to get prescription medications. CANARX offers hundreds of brand-name maintenance medications that you can get — **copay-free** — in just a few easy steps.

SAFE.

Medications are shipped direct to you from licensed and regulated pharmacies located in Canada, the United Kingdom and Australia. All medications are backed by a Quality Assurance Team of doctors and pharmacists, as well as 20-plus years of experience in the industry.

SMART.

With our program, you pay **$0** in copays and your medications are shipped right to your door for **FREE**. How? Your health plan pays less for the medication and shares these savings with you.

Ready to Start Saving?

ENROLL TODAY!

Let's Get Started

JOINING IS EASY!

Visit our website today, for more information including:

- Additional Forms
- Frequently Asked Questions (FAQs)
- Video Overview
- List of Medications

Call 1-866-893-6337 for your plan's WebID.

canarx.com

Scan to go to the website

Before ordering through CANARX, you or your doctor must attest that you have been taking your prescribed medication for at least 30 days – this is to ensure you have not experienced any complications with the medication.

STEP 1
Ask your doctor for a prescription for a **3-month** supply of your maintenance medication with **3 refills.**

STEP 2
Fill out the attached enrollment form or download one from your group website.

STEP 3
Send us your prescription, enrollment form and a copy of your state driver's license or other approved government ID.

STEP 4
CANARX will call you to welcome you to the program and review your order.

STEP 5
A licensed and regulated pharmacy will ship your medication to you in the original manufacturer's sealed packaging.

STEP 6
Refills are worry-free. CANARX will call you prior to each renewal of your prescription to ensure you have a continuous supply.

Submit Your Completed and Signed Enrollment Form, Original Prescription and ID:

By Mail to:

CANARX
PO Box 3009
Windsor, ON Canada
N8N 2M3

Enrollment Form and ID can also be sent by secure upload to:

canarxdocs.com

By Fax to:

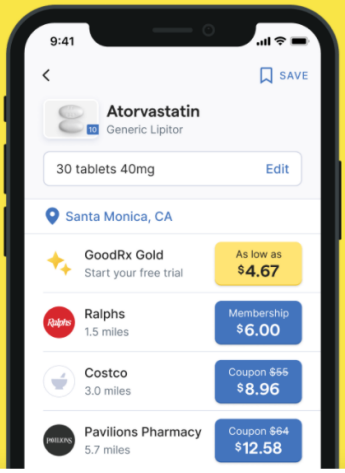
1-866-715-6337

Note: Prescriptions must be faxed directly from the physician's office.

CANARX

GoodRx

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



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

★★★★★ **4.8-star average rating**

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

Download on the App Store | GET IT ON Google Play

Enter your mobile number to get our free app.

Mobile number | Text me the app

Features

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

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

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

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

Welcome to your Revive Benefits

revive

Revive is revolutionizing healthcare access and affordability by offering unparalleled convenience and quality care.

Revive is a virtual care clinic. We deliver you effortless access to healthcare benefits through our member portal or the Revive app, so you can access care whenever it's convenient for you. Complete your enrollment today and gain instant access to on-demand, personalized care.

Signing up is simple:

1. Click the button below, scan the QR code, or go to member.myrevive.health/register

   Register Now

2. You will be taken to a web page where you will be prompted to enter a code. Enter code: **SEDUBOIS17**
3. Next, enter your **First** and **Last Name**, **Email address**, then click **Submit**.
4. You will receive an email to login and complete the registration process to access the program.
5. When asked, create a unique password and click **Submit**.
6. You will now be sent to your personal portal to access the care services that have been selected for you.

Access your Revive personal health care portal any time at: https://member.myrevive.health

Our Customer Care team is here to support you.

Should you have any trouble with registration, accessing your benefits, or scheduling an appointment, reach out to our customer care team.

1-888-220-6650

customercare@revive.health

See separate packet for online enrollment instructions using the member portal at www.dunnbenefit.com.

EMPLOYEE PER PAY CONTRIBUTION SUMMARY

No change in rates for 2026.

EMPLOYEE PER PAY COST FOR MEDICAL BENEFITS	
	Based on 24 bi-weekly pays
$5,000 DEDUCTIBLE	
EMPLOYEE	$25.00
EMPLOYEE + CHILD(REN)	$80.00
EMPLOYEE + SPOUSE	$85.00
FAMILY	$100.00

Additional premiums may be required depending on each individual election and other options available to elect.

PREVENTATIVE CARE

What is preventative care?

Preventive care focuses on maintaining your health and establishing your health status. This may include immunizations, vaccines, physical evaluations, lab work, x-rays and medically appropriate health screenings. During your preventive visit, your doctor will determine what tests or screenings are appropriate for you based on many factors such as your age, gender, overall health status, personal health history and your current symptoms or chronic health concerns.

Recommended Screenings

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

Some examples are:

- **Breast Cancer Screenings**: Women age 40-74 years of age; USPSTF recommends biennial (every other year) screening mammography for women.
- **Colorectal Screenings**: Adults age 45-49 and 50-75 colonoscopy screening every 10 years.
- **Pre-Diabetes Screening**: Adults age 35-70 who are overweight or obese; fasting glucose lab test; every 3 years.

Preventive care can help you avoid potentially serious health conditions and/or obtain early diagnosis and treatment.

ANNUAL COMPLIANCE NOTICES

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

PATIENT PROTECTION AND AFFORDABLE CARE ACT

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

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

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

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

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

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

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

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

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

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

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

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Southeast Dubois County Schools

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

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

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

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

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

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	October 2025 – effective January 1, 2026
Name of Entity/Sender:	Southeast Dubois County Schools
Contact/Position/Office:	Stephanie Boling
Address:	432 E 15th St. Ferdinand, IN 47532
Phone Number:	(812) 817-0900

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDRENS HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**. **If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility** – To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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

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

PAPERWORK REDUCTION ACT STATEMENT

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

CONTINUATION OF COVERAGE UNDER COBRA

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

SPECIAL ENROLLMENT RIGHTS

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

GRANDFATHERED STATUS UNDER HEALTHCARE REFORM

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

GRANDFATHERED STATUS UNDER HEALTHCARE REFORM

You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers contact the plan administrator; or visit your PPO networks website. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization in or to obtain access to obstetrical or gynecological care from a health care professional in network who specializes in obstetrics/gynecology. The health care professional may be required to comply with certain procedures including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating providers who specialize in obstetrics/gynecology contact the plan administrator or visit your PPO networks website.

USERRA HEALTH INSURANCE PROTECTION

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

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION (if applicable)

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the plan may use aggregate information it collects to design a program based on identified health risks in the workplace, it will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to request from you for a reasonable accommodation need to participate in any wellness program (if applicable) or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with any wellness program will not be provided to your employer and may never be used to make decisions regarding your employment. Your health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law to carry out specific activities related to any wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in any wellness program or receiving any incentives. Anyone who receives your information for the purpose of providing you services as part of any wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable information is/are in order to provide you with services under any wellness program. In addition, all information obtained from any wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of any wellness program will be used in making an employment decision. Specify any other or additional

confidentiality protections if applicable. Appropriate precautions will be taken to avoid any data breach and in the event a data breach occurs involving information you provide in connection with any wellness program we will notify you immediately. You may not be discriminated against in employment because if the medical information you provide as participating in any wellness program nor may you be subjected to retaliation if you choose not to participate. If you have any questions regarding this notice or about protections against discrimination/retaliation, please contact the plan administrator.

WELLNESS PLAN ALTERNATIVE STANDARD (if applicable)

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

HHS NON-DISCRIMINATION NOTICE

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

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

PRIVACY NOTICE

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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

YOUR RIGHTS

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

YOUR CHOICES

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

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

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

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

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

Run our organization

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

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues
We can share health information about you for certain situations such as:

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)
Southeast Dubois County Schools		35-2030550
5. Employer address 432 E 15th St		6. Employer phone number (812) 817-0900
7. City Ferdinand	8. State Indiana	9. ZIP code 47532
10. Who can we contact at this job? Stephanie Bolling		
11. Phone number (if different from above)	12. Email address sbolling@sedubois.k12.in.us	

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