	Premier	Healthwise	Healthy Saver
SERVICES	**In-Network**	**In-Network**	**In-Network**
Annual Deductible			
For one person	$500.00	$1,250.00	$3,500.00
Any one member in a family	$500.00	$1,250.00	$3,500.00
For your family	$1,000.00	$2,500.00	$7,000.00
Out-of-Pocket Maximum			
For one person	$3,000.00	$4,500.00	$4,500.00
Any one member in a family	$3,000.00	$4,500.00	$4,500.00
For your family	$6,000.00	$9,000.00	$9,000.00
Doctor's Office Visits			
Primary Care (PCP)	$15.00	$15.00	20% after deductible
Specialists	$35.00	$35.00	20% after deductible
Diagnostic Testing			
X-ray, CT, MRI, Pet Scans	10% after deductible	20% after deductible	20% after deductible
Preventive Care	No Charge	No Charge	No Charge
Hospital Care Services			
Inpatient	10% after deductible	20% after deductible	20% after deductible
Outpatient	10% after deductible	20% after deductible	20% after deductible
Emergency Care			
Urgent Care	$50.00	$50.00	20% after deductible
Emergency Room	$350.00 Copay; then ded	$350.00 Copay; then ded	20% after deductible
Prescription Drugs			
Retail			
Generic	$10.00	$10.00	20% after deductible
Brand/Typically Preferred	$35.00	$35.00	20% after deductible
Typically Non-Preferred	$75.00	$75.00	20% after deductible
Specialty	25% up to $350	25% up to $350	20% after deductible
Mail Order			
Generic	$30.00	$30.00	20% after deductible
Brand/Typically Preferred	$105.00	$105.00	20% after deductible
Typically Non-Preferred	$225.00	$225.00	20% after deductible
Specialty (may not be available w/mail order)	25% up to $350	25% up to $350	20% after deductible

City of Elkhart
Human Resources Department

2023 Medical Plan Semi-Monthly Rates
Full Time Employees participating in the Wellness Program
DISCOUNTED RATES

Medical Plan Options

Premier Plan	Single	Employee + Spouse	Employee + Child	Familiy
Employee Contribution	$111.70	$245.73	$188.76	$319.44
City Contribution	$335.95	$739.10	$567.76	$960.83
Total	$447.65	$984.83	$756.52	$1,280.27

Healthwise Plan	Single	Employee + Spouse	Employee + Child	Familiy
Employee Contribution	$60.76	$133.67	$102.68	$173.70
City Contribution	$345.09	$759.20	$583.20	$986.95
Total	$405.85	$892.87	$685.88	$1,160.65

Healthy Saver	Single	Employee + Spouse	Employee + Child	Familiy
Employee Contribution	$34.49	$75.88	$58.29	$98.64
City Contribution	$297.25	$653.94	$502.35	$850.13
Total	$331.74	$729.82	$560.64	$948.77

City of Elkhart
Human Resources Department

2023 Medical Plan Semi-Monthly Rates
Full Time Employees - non-participating in the Wellness Program
NON-DISCOUNTED RATES

Medical Plan Options

Premier Plan	Single	Employee + Spouse	Employee + Child	Familiy
Employee Contribution	$167.34	$365.33	$287.98	$450.82
City Contribution	$280.31	$619.49	$468.54	$829.45
Total	$447.65	$984.82	$756.52	$1,280.27

Healthwise Plan	Single	Employee + Spouse	Employee + Child	Familiy
Employee Contribution	$110.21	$239.65	$191.43	$287.43
City Contribution	$295.64	$653.21	$494.45	$873.29
Total	$405.85	$892.86	$685.88	$1,160.72

Healthy Saver	Single	Employee + Spouse	Employee + Child	Familiy
Employee Contribution	$80.74	$174.83	$141.64	$203.16
City Contribution	$250.99	$554.99	$418.99	$745.61
Total	$331.73	$729.82	$560.63	$948.77

Your summary of benefits

Anthem

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Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO

Your Network: Blue Access

City of Elkhart

Effective 01/01/2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$500 person / $1,000 family	$1,000 person / $2.000 family
Overall Out-of-Pocket Limit	$3,000 person / $6,000 family	$6,000 person / $12,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at $0 per visit medical deductible does not apply.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at $0 copay per visit medical deductible does not apply.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	$15 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Specialist Care *virtual and office*	$35 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$15 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	$40 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for a $25 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Surgery	$40 copay per visit medical deductible does not apply‡	30% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	No charge	30% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
X-Ray		
Office	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Radiology Center	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$50 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$350 copay per visit and 10% coinsurance medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance medical deductible does not apply	Covered as In-Network
Ambulance	10% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor Services	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Ambulatory Surgical Center	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Ambulatory Surgical Center	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	No charge	50% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period.*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for occupational therapy is limited to 20 visits per benefit period, physical therapy is limited to 20 visits per benefit period and speech therapy is limited to 20 Visits per benefit period..*		
Office	$40 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is limited to 20 visits per benefit period.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	$40 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$40 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis		
Office	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	$40 copay per visit medical deductible does not apply‡	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is limited to 100 days combined per benefit period.*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Inpatient Hospice	No charge	No charge

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National*** *Drugs not included on the drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.*		
Tier 1 - Typically Generic	$10 copay per prescription, deductible does not apply (retail) and $10 copay per prescription, deductible does not apply (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	$35 copay per prescription, deductible does not apply (retail) and $35 copay per prescription,	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
	deductible does not apply (home delivery)	
Tier 3 - Typically Non-Preferred Brand	$75 copay per prescription, deductible does not apply (retail) and $75 copay per prescription, deductible does not apply (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to $350 per prescription, deductible does not apply (retail and home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out of pocket limit.		
Children's Vision exam (up to age 19) *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $42

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 578-4441

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 578-4441 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 578-4441:

Chinese(□ □)□ (833) 578-4441。

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 578-4441 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 578-4441.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 578-4441.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 578-4441.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(833) 578-4441 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 578-4441로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (833) 578-4441.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 578-4441.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 578-4441 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 578-4441.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 578-4441.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 578-4441.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 578-4441.

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Your summary of benefits

Anthem

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Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO

Your Network: Blue Access

City of Elkhart

Effective 01/01/2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$1,250 person / $2,500 family	$3,000 person / $6,000 family
Overall Out-of-Pocket Limit	$4,500 person / $9,000 family	$9,000 person / $18,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at $0 copay per visit medical deductible does not apply.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at $0 copay per visit medical deductible does not apply.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Care *virtual and office*	$35 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for a $25 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	$50 copay per visit medical deductible does not apply‡	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	No charge	40% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
X-Ray		
Office	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$350 copay per visit and 20% coinsurance medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance medical deductible does not apply	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	No charge	50% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for occupational therapy is limited to 20 visits per benefit period, physical therapy is limited to 20 visits per benefit period and speech therapy is limited to 20 visits per benefit period.*		
Office	$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is limited to 20 visits per benefit period.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis		
Office	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	$50 copay per visit medical deductible does not apply‡	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is limited to 150 days combined per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	No charge	No charge

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National*** *Drugs not included on the drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.*		
Tier 1 - Typically Generic	$10 copay per prescription, deductible does not apply (retail) and $10 copay per prescription, deductible does not apply (home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	$35 copay per prescription, deductible does not apply (retail) and $35 copay per prescription,	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
	deductible does not apply (home delivery)	
Tier 3 - Typically Non-Preferred Brand	$75 copay per prescription, deductible does not apply (retail) and $75 copay per prescription, deductible does not apply (home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to $350 per prescription, deductible does not apply (retail and home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out of pocket limit.		
Children's Vision exam (up to age 19) *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $42

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- Benefit Period: Calendar Year

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details,

important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 578-4441

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 578-4441 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 578-4441:

Chinese(□ □)□ □
□ □ □ □ □ (833) 578-4441。

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 578-4441 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 578-4441.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 578-4441.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 578-4441.

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(833) 578-4441　　にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 578-4441로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (833) 578-4441.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 578-4441.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 578-4441 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 578-4441.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 578-4441.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 578-4441.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 578-4441.

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Your summary of benefits

Anthem

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Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA

Your Network: Blue Access

City of Elkhart

Effective 01/01/2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$3,500 person / $7,000 family	$7,000 person / $14,000 family
Overall Out-of-Pocket Limit	$4,500 person / $9,000 family	$9,000 person / $18,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at no charge per visit after deductible is met.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at 20% coinsurance after deductible is met.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care *virtual and office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care includes doctor services. Additional charges may apply depending on the care provided.	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for occupational therapy is limited to 20 visits per benefit period, physical therapy is limited to 20 visits per benefit period, and speech therapy is limited to 20 visits per benefit period.*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital* *Coverage is limited to 20 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is limited to 100 days combined per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Inpatient Hospice	20% coinsurance after deductible is met	Covered as In-Network
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National*** *Drugs not included on the drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.*		
Tier 1 - Typically Generic	20% coinsurance after deductible is met (retail and home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	20% coinsurance after deductible is met (retail and home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	20% coinsurance after deductible is met (retail and home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance after deductible is met (retail and home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out of pocket limit.		

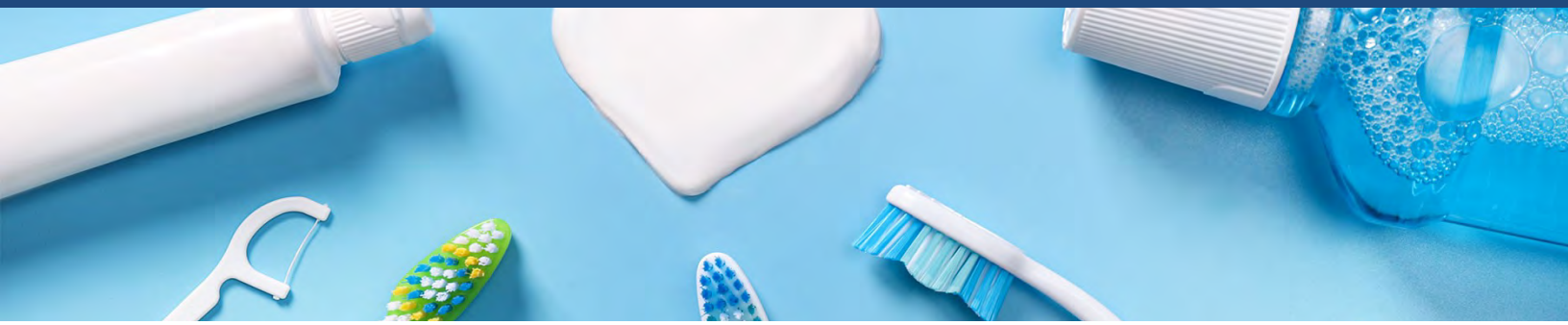
Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Children's Vision exam (up to age 19) *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $42

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Benefit Period: Calendar Year

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Voluntary Dental Insurance



Health Resources, Inc. - Paramount Dental

The City of Elkhart covers 50% of your Dental premiums to make dental coverage more affordable for everyone!

Coverage	DHO 2 Core	DHO 3 Enhanced	DHO 4 Premier
	In-Network	In-Network	In-Network
Deductible			
Individual	$0	$0	$0
Family	$0	$0	$0
Calendar Year Maximum	$1,000	$2,500	$2,500
Diagnostic & Preventative	Covered at 100%	Covered at 100%	Covered at 100%
Basic Restorative			
Fillings	Covered at 50%	Covered at 80%	Covered at 80%
Simple Extractions	Covered at 50%	Covered at 80%	Covered at 80%
Major Restorative (Crowns, Dentures, Bridges)			
Crowns	N/A	Covered at 50%	Covered at 80%
Dentures	N/A	Covered at 50%	Covered at 50%
Bridges	N/A	Covered at 50%	Covered at 50%
Orthodontics	N/A	50% up to the life $1,500	50% up to the life $2,500

See Certificate of Coverage for full policy details including limits and exclusions – for a copy see Human Resources.

Out-of-Network Benefits match In-Network Benefits. *In-network dentists have agreed to accept discounts on covered dental services which allows for your benefit dollars to go further. Whereas out-of-network dentists are under no obligation to accept contracted fees. If there is a difference between the allowed reimbursement and the amount the dentist charges for the service, you are responsible for this difference. Therefore, your coinsurance may vary from the figures outlined above.

2023 Semi-Monthly Dental Rates (24 Deductions) *Premiums below reflect 50% City contribution*			
Dental Tier	**DHO 2 Core**	**DHO 3 Enhanced**	**DHO 4 Premier**
Employee	$4.08	$9.55	$11.18
Employee + Spouse	$8.16	$19.03	$22.28
Employee + Child(ren)	$10.25	$21.87	$25.61
Family	$17.50	$34.00	$39.80

PARAMOUNT DENTAL
Affiliate of ProMedica

Basic Plan
Product Summary Guide for City of Elkhart Indiana 2

H

DHO 2 (January - December)

Plan Annual Maximum Benefit:	$1,000	
Diagnostic & Preventive	**In Network**	**Out of Network***
Exams – periodic, limited, comprehensive	Covered at 100%	Covered at 100%
Radiographs – full mouth series, panoramic, bitewings	Covered at 100%	Covered at 100%
Fluoride	Covered at 100%	Covered at 100%
Routine teeth cleaning	Covered at 100%	Covered at 100%
Sealants	Covered at 100%	Covered at 100%
Restorative & Prosthodontics		
Fillings - silver or white (anterior and posterior teeth)	Covered at 50%	Covered at 50%
Protective restorations	Covered at 50%	Covered at 50%
Oral Surgery		
Simple extractions	Covered at 50%	Covered at 50%
Impactions	Covered at 50%	Covered at 50%
Surgical extractions	Covered at 50%	Covered at 50%
Deductible (Not applicable on Diagnostic & Preventive):	**None**	**None**

*In-network dentists have agreed to accept discounts on covered dental services which allows for your benefit dollars to go further. Whereas out-of-network dentists are under no obligation to accept contracted fees. If there is a difference between the allowed reimbursement and the amount the dentist charges for the service, you are responsible for this difference. Therefore, your coinsurance may vary from the figures outlined above.

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

To find a dentist visit: InsuringSmiles.com/FindADentist

PARAMOUNT DENTAL
Affiliate of ProMedica

Enhanced Plan
Product Summary Guide for City of Elkhart Indiana 3A

I

DHO 3 (January - December)

Plan Annual Maximum Benefit:	$2,500	
Diagnostic & Preventive	**In Network**	**Out of Network***
Exams – periodic, limited, comprehensive	Covered at 100%	Covered at 100%
Radiographs – full mouth series, panoramic, bitewings	Covered at 100%	Covered at 100%
Fluoride	Covered at 100%	Covered at 100%
Routine teeth cleaning	Covered at 100%	Covered at 100%
Sealants	Covered at 100%	Covered at 100%
Restorative & Prosthodontics		
Fillings - silver or white (anterior and posterior teeth)	Covered at 80%	Covered at 80%
Core build ups	Covered at 50%	Covered at 50%
Crowns – porcelain, ceramic, stainless steel	Covered at 50%	Covered at 50%
Protective restorations	Covered at 50%	Covered at 50%
Removable dentures	Covered at 50%	Covered at 50%
Endodontics & Periodontics		
Root canal therapy – anterior, posterior	Covered at 80%	Covered at 80%
Root canal therapy – retreatment	Covered at 80%	Covered at 80%
Scaling and root planing	Covered at 50%	Covered at 50%
Full mouth debridement	Covered at 50%	Covered at 50%
Periodontal maintenance	Covered at 50%	Covered at 50%
Oral Surgery		
Simple extractions	Covered at 80%	Covered at 80%
Impactions	Covered at 50%	Covered at 50%
Surgical extractions	Covered at 50%	Covered at 50%
Miscellaneous		
Emergency palliative treatment	Covered at 50%	Covered at 50%
Anesthesia – general and IV sedation	Covered at 50%	Covered at 50%
Athletic mouthguards	Covered at 50%	Covered at 50%
Deductible (Not applicable on Diagnostic & Preventive):	**None**	**None**
Lifetime Orthodontic Benefit (Adult/Dep):	**$1,500**	

Procedures listed herein are payable up to the lifetime maximum benefit, not to exceed the maximum monthly installment. To receive maximum benefit, the patient must be in active orthodontic treatment a minimum of two years while covered by the Plan. Once an individual has exhausted his/her lifetime maximum benefit under any Plan, additional charges will be excluded.

Limited Orthodontic Treatment
Interceptive Orthodontic Treatment
Comprehensive Orthodontic Treatment
Treatment to Control Harmful Habits

*In-network dentists have agreed to accept discounts on covered dental services which allows for your benefit dollars to go further. Whereas out-of-network dentists are under no obligation to accept contracted fees. If there is a difference between the allowed reimbursement and the amount the dentist charges for the service, you are responsible for this difference. Therefore, your coinsurance may vary from the figures outlined above.

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

To find a dentist visit: InsuringSmiles.com/FindADentist

PARAMOUNT DENTAL
Affiliate of ProMedica

Premier Plan
Product Summary Guide for
City of Elkhart 4A
DHO 4 (January - December)

J

Plan Annual Maximum Benefit:	$2,500	
Diagnostic & Preventive	**In Network**	**Out of Network***
Exams – periodic, limited, comprehensive	Covered at 100%	Covered at 100%
Radiographs – full mouth series, panoramic, bitewings	Covered at 100%	Covered at 100%
Fluoride	Covered at 100%	Covered at 100%
Routine teeth cleaning	Covered at 100%	Covered at 100%
Sealants	Covered at 100%	Covered at 100%
Restorative & Prosthodontics		
Core build ups	Covered at 80%	Covered at 80%
Crowns – porcelain, ceramic, stainless steel	Covered at 80%	Covered at 80%
Fillings - silver or white (anterior and posterior teeth)	Covered at 80%	Covered at 80%
Protective restorations	Covered at 80%	Covered at 80%
Removable dentures	Covered at 50%	Covered at 50%
Endodontics & Periodontics		
Root canal therapy – anterior, posterior	Covered at 80%	Covered at 80%
Root canal therapy – retreatment	Covered at 80%	Covered at 80%
Scaling and root planing	Covered at 80%	Covered at 80%
Full mouth debridement	Covered at 50%	Covered at 50%
Periodontal maintenance	Covered at 50%	Covered at 50%
Oral Surgery		
Simple extractions	Covered at 80%	Covered at 80%
Impactions	Covered at 80%	Covered at 80%
Surgical extractions	Covered at 80%	Covered at 80%
Miscellaneous		
Emergency palliative treatment	Covered at 50%	Covered at 50%
Anesthesia – general and IV sedation	Covered at 50%	Covered at 50%
Athletic mouthguards	Covered at 50%	Covered at 50%
Deductible (Not applicable on Diagnostic & Preventive):	**None**	**None**
Lifetime Orthodontic Benefit (Adult/Dep):	**$2,500**	

Procedures listed herein are payable up to the lifetime maximum benefit, not to exceed the maximum monthly installment. To receive maximum benefit, the patient must be in active orthodontic treatment a minimum of two years while covered by the Plan. Once an individual has exhausted his/her lifetime maximum benefit under any Plan, additional charges will be excluded.

Limited Orthodontic Treatment
Interceptive Orthodontic Treatment
Comprehensive Orthodontic Treatment
Treatment to Control Harmful Habits

*In-network dentists have agreed to accept discounts on covered dental services which allows for your benefit dollars to go further. Whereas out-of-network dentists are under no obligation to accept contracted fees. If there is a difference between the allowed reimbursement and the amount the dentist charges for the service, you are responsible for this difference. Therefore, your coinsurance may vary from the figures outlined above.

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To find a dentist visit: InsuringSmiles.com/FindADentist

Voluntary Vision Insurance

EyeMed

K

Vision care plans provide coverage for the nonsurgical improvement of eyesight, including coverage for eyeglasses and contact lenses. Coverage typically is limited and is subject to applicable copayments or scheduled cash allowances.

	Frequency	In-Network Insight	Out-of-Network
Examination	12 Mos	$10 Copay	Reimbursement up to $40
Standard Lenses	12 Mos		
Single / Vision	12 Mos	Covered at 100% after $25 Materials Copay	Reimbursement up to $30
Bifocal	12 Mos	Covered at 100% after $25 Materials Copay	Reimbursement up to $50
Trifocal	12 Mos	Covered at 100% after $25 Materials Copay	Reimbursement up to $70
Lenticular	12 Mos	Covered at 100% after $25 Materials Copay	Reimbursement up to $70
Frames	12 Mos	$0 Copay; 20% off balance over $130 Allowance	Reimbursement up to $91
Contact Lens - In lieu of eyeglasses			
Evaluation and fitting	12 Mos		
Conventional	12 Mos	$0 Copay; 15% off balance over $130 Allowance	Reimbursement up to $91
Disposable	12 Mos	$0 Copay; 100% off balance over $130 Allowance	Reimbursement up to $91
Medically Necessary	12 Mos	$0 Copay; Paid-in-Full	Reimbursement up to $210

Additional Benefits

- 40% off additional pairs of glasses and a 15% discount on conventional lenses once funded benefit is used – an industry exclusive.
- 20% off any item not covered by the plan, including non-prescription sunglasses.
- Lasik or PRK from US Laser Network 15% off retail price or 5% off promotional price.
- Hearing Care: Amplifon Hearing Health Care Network—40% off hearing exams and a low price guarantee on discounted hearing aids.

See Certificate of Coverage for full policy details including limits and exclusions – for a copy see Human Resources.
To identify an in-network provider go to www.eyemed.com.

2023 Semi-Monthly Vision Rates (24 Deductions)	
Employee	$3.10
Employee + Spouse	$5.89
Employee + Child(ren)	$6.14
Family	$9.11

EXPERIENCE MORE: ONLINE ACCESS

HOW TO: enjoy your own eye site

MEMBER WEB ON EYEMED.COM

Your vision plan is like a friendly smile – it doesn't do any good if it's hidden away. Member Web at eyemed.com is here, there and everywhere. It's your vision plan control center. A place to manage the details of every visit and every claim. Instantly. Easily. Smile-ly.

START MANAGING YOUR BENEFITS IN A FEW EASY STEPS:

1. Visit eyemed.com and click on Member Login.
2. If you're a new user, click on Create an Account.
3. Register using your member ID or the last four digits of your social security number (You'll get an email asking to confirm your account.). *
4. Finish setting up your new account with your email address and a password (To keep it secure, we list some password "musts.").
5. Come back anytime to change your password, email address and billing preferences (It's all under Manage Profiles.).

LOG IN 24/7 TO:

- View your benefit details
- Confirm eligibility
- Check claim status
- Print replacement ID cards
- Locate a provider
- Schedule an appointment online**
- View health and wellness information
- Get special offers

SEE THE GOOD STUFF

Register on eyemed.com or grab the member app (App Store or Google Play) now.

** Depends on how your benefit administrator entered you into the system.*
*** Most, but not all, network providers offer this.*

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL sears OPTICAL

PDF-1801-M-134

EXPERIENCE MORE: MOBILE ACCESS

HOW TO: mobilize your vision plan

EYEMED MEMBERS APP

Our member app was the first of its kind. But innovation – like your life – never stops. The EyeMed Members App is packed with ahead-of-the-game resources wherever you are. Before, during and after your eye appointment.

Get the latest EyeMed Members App:

1. **DOWNLOAD** – Search "EyeMed Members" in your App store, iTunes or Google Play.
2. **OPEN** – You can use some features right away; others unlock once you register.
3. **REGISTER** – You'll need your member ID or the last four digits of your social security number.
4. **LOG IN** – If you've already registered on eyemed.com, you can log onto the app the same way.

	Ready when you download	Unlocked when you register
Find nearby network providers	●	
On-the-fly appointment scheduling	●	
Turn by turn directions and map	●	
Eye exam and contact lens reminders		●
Electronic ID card for office visits		●
Save vision prescriptions*		●
Benefit plan details		●
Answers to common questions	●	
Special offers and discounts		●
Direct line to EyeMed support	●	

SEE THE GOOD STUFF

Register on eyemed.com or grab the member app (App Store or Google Play) now.

** Take a picture of your prescription and store it in your app. No need to type in the numbers.*

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL sears OPTICAL

CLAIM FORM 1: REIMBURSEMENT
FOR OUT-OF-NETWORK BENEFIT

Out-of-Network Claims if you have Out-of-Network Benefits

Use this form if you receive vision services from an out-of-network eye doctor and you have out-of-network benefits. If your plan does not include out-of-network benefits, please see the Network Exceptions form, claim form 2, for separate processing instructions.

If you are a Medicare member, you may use this form or just submit a written request with all information that would be on the form.

To request reimbursement, please complete and sign the itemized claim form.
Return the completed form and your itemized paid receipts to:

First American Administrators, Inc.
Attn: OON Claims, PO Box 8504, Mason, OH 45040-7111

Patient Last Name†

Patient First Name†

MI

Birth Date (MM/DD/YYYY)†

Street Address†

City†

State†

Zip Code†

Patient Member ID #

Relationship to Subscriber†

Self ◯ Dependent ◯

†Required

continued

CLAIM FORM 1: REIMBURSEMENT FOR OUT-OF-NETWORK BENEFIT

Subscriber Last Name†

Subscriber First Name†

MI

Birth Date (MM/DD/YYYY)†

Street Address†

City†

State†

Zip Code†

Vision Plan Name

Date of Service† (MM/DD/YYYY)

Vision Plan Group #

Subscriber Member ID #

Doctor or Store where patient received services

Provider's Name†

Provider's NPI

Provider Street Address†

City†

State†

Zip Code†

†Required

continued

Request for Reimbursement

Enter Amount Charged.† Remember to include itemized paid receipts.†

Service Type	Amount Charged	Lens Type	Please Check	Lens Options: (if purchased)	Amount Charged
Exam *92014*	$	Single *V2100*	☐	Anti-Reflective *V2750*	$
Refraction *92015*	$	Bifocal *V2200*	☐	Polycarbonate *V2784*	$
Frame *V2025*	$	Trifocal *V2300*	☐	Scratch *V2760*	$
Contact Lens *S0500*	$	Progressive *V2781*	☐	Tint *V2745*	$
Contact Lens Fitting *92310*	$	Prem Prog *V278126*	☐	UV *V2755*	$
Lenses	$	Other	$	Roll and Polish *V2702*	$

Enter Total Amount Paid as shown on receipt, excluding sales tax† $

I certify that I have read the state fraud warnings. If I want a printed copy, I can contact the customer call center. I understand that I may be denied reimbursement if I am not eligible for out-of-network benefits or if I do not supply the requested information for the claim. I authorize any insurance company, organization employer, ophthalmologist, optometrist and optician to release any information with respect to this claim. I agree with all statements above and certify all of the information furnished on this form is true and correct.

Member/Guardian/Patient Signature (not a minor)† Date

†Required

City of Elkhart

Healthcare that gives more.

City of Elkhart now offers Everside Health as part of your benefits package. It's an easier, more convenient healthcare option for everything from screenings and prevention to chronic disease management and urgent care.

As an Everside Health member, you can:

- Schedule same-day and next-day appointments.
- Meet with your provider where it's easiest for you: at a health center near you, online, or over the phone.
- Reach your care team 24/7 for urgent needs.
- Spend as much time as you need with a provider who will get to know you.
- Get care for nearly every health issue. (And if you need a referral, your care team will handle it for you.)

Schedule your welcome visit.
Get to know your provider (in-person, by phone, or online) and go over your heath history so you can get the right care when you need it most.

Get the everside app or make an appointment today at
574-206-4156 or **members.eversidehealth.com**

everside HEALTH™

City of Elkhart

Offering primary care & women's health

Looking for a one stop shop for compassionate women's healthcare? Look no further than Everside Health.

With your Everside Health benefits, you have dedicated access to a personal primary care provider. At Everside Health, we care for you as though you're our own family. Everside is available as an added benefit of your health plan at no cost.

- Comprehensive primary care such as preventive, urgent, and sick care
- Women's health services including GYN exams
- Skin checks to assess skin cancer risks
- Health and wellness coaching
- Mental health services
- Nutrition counseling
- Weight management

To schedule an appointment, call 574-206-4156.

Download the Everside Health app to create an account or schedule an appointment.
For more information, visit
eversidehealth.com/cityofelkhart

everside HEALTH™

City of Elkhart

Camp and sports physicals **at no cost**

Schedule your child's free camp or sports physical with no copay or deductible.

Everside Health offers comprehensive, coordinated care for the entire family

- Same- or next-day appointments for urgent needs
- Healthy lifestyle coaching
- Chronic condition management
- Care coordination
- Women's health
- Pediatrics
- Many onsite labs and medications at no additional cost

Download the Everside Health app to create an account or schedule an appointment.

For more information, visit **eversidehealth.com/cityofelkhart**

everside HEALTH™

City of Elkhart

Offering the time and personal attention you deserve to manage chronic conditions

R

We're here to help

At Everside Health, you'll find a trusting personal provider with the time needed to partner with you to get back on track with managing any chronic conditions or health concerns such as diabetes, hypertension, or even weight management.

- Personalized education and counseling
- Ongoing in-person and virtual access to your provider
- Convenient, unhurried appointments that work with your busy schedule
- Onsite blood work and lab monitoring
- No-cost medications when available and dispensed at the health center
- A custom treatment plan and goals
- The ability to discuss multiple issues or concerns during a single appointment

With your City of Elkhart health benefits, you have dedicated access to a personal primary care provider with Everside Health. Everside Health is available as an added benefit of your health plan at no cost to eligible employees and their covered dependents.

To schedule, call **574-206-4156**
For more information, visit **eversidehealth.com/cityofelkhart**

everside HEALTH

Skip the trip to the pharmacy

Fill many common prescriptions at your health center.

Brand name	Generic name	Dose/Qty.
ACID REDUCER	FAMOTIDINE	20MG TAB #90
ADRENACLICK	EPINEPHRINE	0.3MG/0.3 AUTO #2
ALBUTEROL SULFATE	ALBUTEROL SULFATE	2.5MG/3ML VIAL 75 ML
ALCAINE	PROPARACAINE HCL	0.5 % DROP 15 ML
ALLERGY RELIEF	FEXOFENADINE HCL	180MG TAB #90
AMOXICILLIN	AMOXICILLIN	250MG/5ML SUSP 150 ML
AMOXICILLIN	AMOXICILLIN	400MG/5ML SUSP 100 ML
AMOXICILLIN	AMOXICILLIN	500MG CAP #30
AUGMENTIN	AMOXICILLIN/POTASSIUM CLAV	875-125MG TAB #20
AVIDOXY	DOXYCYCLINE MONOHYDRATE	100MG TAB #20
BACTRIM DS	SULFAMETHOXAZOLE/TRIMETHOPRIM	800-160MG TAB #14
BACTROBAN	MUPIROCIN 2% 22GM	2% 22GM OINT 22 GM
BENICAR	OLMESARTAN MEDOXOMIL	20MG TAB #30
BENICAR	OLMESARTAN MEDOXOMIL	20MG TAB #90
BENICAR	OLMESARTAN MEDOXOMIL	40MG TAB #30
BENICAR	OLMESARTAN MEDOXOMIL	40MG TAB #90
BUSPAR	BUSPIRONE	10MG TAB #90
CALAN SR	VERAPAMIL HCL ER	120MG TAB #90
CEFTRIAXONE	CEFTRIAXONE SODIUM	500MG VIAL #1
CETIRIZINE HCL	CETIRIZINE HCL	5MG TAB #30
CETIRIZINE HYDROCHLORIDE	CETIRIZINE HCL	10MG TAB #90
CIPRO	CIPROFLOXACIN HCL	500MG TAB #20
CORTISPORIN	NEOMYCIN/POLYMYXIN B/HYDROCORT	3.5-10K-1 SOL 10 ML
COZAAR	LOSARTAN POTASSIUM	100MG TAB #90
COZAAR	LOSARTAN POTASSIUM	25MG TAB #90
COZAAR	LOSARTAN POTASSIUM	50MG TAB #90
CRESTOR	ROSUVASTATIN CALCIUM	10MG TAB #90
CRESTOR	ROSUVASTATIN CALCIUM	20MG TAB #90
DIFLUCAN	FLUCONAZOLE	150MG TAB #1
EASY TOUCH GLUCOSE MONITORING KIT	EASY TOUCH GLUCOSE MONITORING KIT	KIT #1
EASY TOUCH GLUCOSE TEST STRIPS	EASY TOUCH GLUCOSE TEST STRIPS	STRI #50
EFFEXOR ER	VENLAFAXINE HCL ER	75MG CAP #90
EFFEXOR XR	VENLAFAXINE HCL ER	150MG CAP #90
EPIPEN JR 2-PAK	EPINEPHRINE	0.15MG/0.3 AUTO #2
FLEXERIL	CYCLOBENZAPRINE HCL	10MG TAB #30
FLEXERIL	CYCLOBENZAPRINE HCL	5MG TAB #30
FLONASE	FLUTICASONE PROPIONATE	50MCG SPY 16 GM
GLUCOPHAGE	METFORMIN HCL	1000MG TAB #90
GLUCOPHAGE	METFORMIN HCL	500MG TAB #90
GLUCOPHAGE ER	METFORMIN HCL ER	500MG TAB #90

Call your health center today 574-206-4156

to set up an account or make an appointment.

everside HEALTH™

Skip the trip to the pharmacy

Fill many common prescriptions at your health center.

Brand name	Generic name	Dose/Qty.
HYDROCHLOROTHIAZIDE	HYDROCHLOROTHIAZIDE	25MG TAB #90
IMITREX	SUMATRIPTAN SUCCINATE	50MG TAB #9
INDAPAMIDE	INDAPAMIDE	1.25MG TAB #100
INDAPAMIDE	INDAPAMIDE	2.5MG TAB #100
KEFLEX	CEPHALEXIN	500MG CAP #30
LABELS	MEDICAL SUPPLY, MISCELLANEOUS	EACH #300
LEXAPRO	ESCITALOPRAM OXALATE	10MG TAB #30
LEXAPRO	ESCITALOPRAM OXALATE	10MG TAB #90
LEXAPRO	ESCITALOPRAM OXALATE	20MG TAB #90
LIPITOR	ATORVASTATIN CALCIUM	10MG TAB #90
LIPITOR	ATORVASTATIN CALCIUM	20MG TAB #90
LIPITOR	ATORVASTATIN CALCIUM	40MG TAB #90
LOPRESSOR	METOPROLOL TARTRATE	25MG TAB #90
LORATADINE	LORATADINE	10MG TAB #90
LOTRISONE	CLOTRIMAZOLE-BETAMETHASONE	0.05%-1% 15 CREA 15 GM
MACROBID	NITROFURANTOIN MONOHYD/M-CRYST	100MG CAP #14
MEDROL	METHYLPREDNISOLONE	4MG TAB #21
MICROZIDE	HYDROCHLOROTHIAZIDE	12.5MG CAP #90
MOBIC	MELOXICAM	15MG TAB #30
MONODOX	DOXYCYCLINE MONOHYDRATE	100MG CAP #20
MOTION SICKNESS	MECLIZINE HCL	25MG TAB #30
MOTRIN	IBUPROFEN	800MG TAB #30
MUCINEX	GUAIFENESIN	600MG TAB #20
NAPROSYN	NAPROXEN	500MG TAB #30
NEO -POLY -HC OTIC EAR SUSP	NEOMYCIN/POLYMYXIN B/HYDROCORT	3.5-10K-1 DROP 10 ML
NORVASC	AMLODIPINE BESYLATE	10MG TAB #90
NORVASC	AMLODIPINE BESYLATE	5MG TAB #90
OCUFLOX	OFLOXACIN	0.3 % DROP 5 ML
OMNICEF	CEFDINIR	300MG CAP #20
PHARMACY BAGS (LARGE)	PHARMACY BAGS (LARGE)	EACH #1
PHILLIPS OPTICHAMBER	INHALER, ASSIST DEVICES	SPAC #1
POLYTRIM	POLYMYXIN B SULF/TRIMETHOPRIM	10000-1/ML DROP 10 ML
PREDNISONE	PREDNISONE	20MG TAB #15
PRILOSEC	OMEPRAZOLE	20MG CAP #90
PRILOSEC	OMEPRAZOLE	40MG CAP #90
PRINIVIL	LISINOPRIL	20MG TAB #90
PROMETHAZINE HCL	PROMETHAZINE HCL	25MG TAB #20
PROMETHAZINE HCL	PROMETHAZINE HCL	25MG TAB #30
PROZAC	FLUOXETINE HCL	10MG CAP #30
PROZAC	FLUOXETINE HCL	20MG CAP #90

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to set up an account or make an appointment.

everside HEALTH™

Skip the trip to the pharmacy

Fill many common prescriptions at your health center.

Brand name	Generic name	Dose/Qty.
ROMYCIN	ERYTHROMYCIN BASE	5MG/GRAM OINT 3.5 GM
SILVADENE	SILVER SULFADIAZINE	1% CREA 50 GM
SINGULAIR	MONTELUKAST SODIUM	10MG TAB #30
SINGULAIR	MONTELUKAST SODIUM	10MG TAB #90
TESSALON	BENZONATATE	200MG CAP #30
TOPROL ER	METOPROLOL SUCCINATE	50MG TAB #90
TOPROL XL	METOPROLOL SUCCINATE	25MG TAB #90
TRAZODONE HCL	TRAZODONE HCL	50MG TAB #90
TRIAMCINOLONE ACETONIDE	TRIAMCINOLONE ACETONIDE	0.1% OINT 15 GM
TRIDERM	TRIAMCINOLONE ACETONIDE	0.1% CREA 30 GM
TRUE PLUS LANCETS	LANCETS	33 GAUGE EACH #100
VENTOLIN HFA	ALBUTEROL SULFATE	90MCG HFA 18 GM
VENTOLIN HFA	ALBUTEROL SULFATE	90MCG HFA 8 GM
VITAMIN D	ERGOCALCIFEROL (VITAMIN D2)	1250MCG CAP #8
VITAMIN D3	CHOLECALCIFEROL VITAMIN D3	5000 UNIT CAP #100
WELLBUTRIN SR	BUPROPION HCL	150MG TAB #60
WELLBUTRIN XL	BUPROPION HCL XL	300MG TAB #90
WELLBUTRIN XL	BUPROPION XL	150MG TAB #90
ZESTRIL	LISINOPRIL	10MG TAB #90
ZESTRIL	LISINOPRIL	40MG TAB #90
ZETIA	EZETIMIBE	10MG TAB #90
ZITHROMAX	AZITHROMYCIN	250MG TAB #6
ZOCOR	SIMVASTATIN	20MG TAB #90
ZOCOR	SIMVASTATIN	40MG TAB #90
ZOFRAN	ONDANSETRON	4MG TAB #30
ZOFRAN	ONDANSETRON HCL	4MG TAB #20
ZOFRAN ODT	ONDANSETRON	4MG TAB #30
ZOFRAN ODT	ONDANSETRON ODT	4MG TAB #20
ZOLOFT	SERTRALINE HCL	100MG TAB #90
ZOLOFT	SERTRALINE HCL	25MG TAB #30
ZOLOFT	SERTRALINE HCL	25MG TAB #90
ZOLOFT	SERTRALINE HCL	50MG TAB #90
ZOVIRAX	ACYCLOVIR	400MG TAB #30
ZOVIRAX	ACYCLOVIR	400MG TAB #60
ZYLOPRIM	ALLOPURINOL	100MG TAB #90
ZYLOPRIM	ALLOPURINOL	300MG TAB #90

Call your health center today 574-206-4156

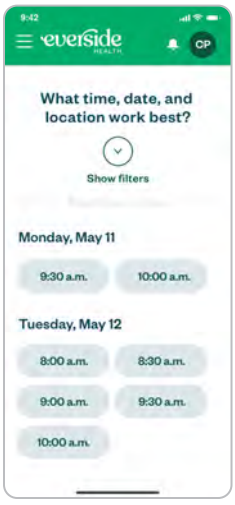
to set up an account or make an appointment.

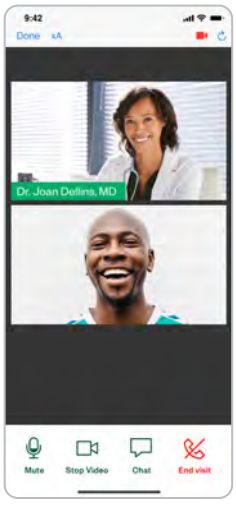
everside HEALTH™

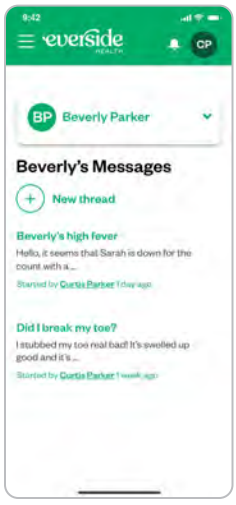
Everside.
By your side, online.

The Everside mobile app and member website is now available to you.

- Easy appointment scheduling
- Chat feature connects you directly with your care team
- Start video visits within the app or browser
- Mobile app available for iOS and Android (or you can use the web)







Set up your account and get started today!

Members can set up a new account by visiting members.eversidehealth.com or by downloading the free app by searching for "Everside Health" on the Apple App Store or Google Play Store

Download on the App Store

GET IT ON Google Play

Questions?
866-808-6005 or MemberServices@eversidehealth.com

everside HEALTH™

City of Elkhart

Get to know your provider before you need them

At Everside Health, we do things a bit differently. We want you to schedule an appointment with your provider *before* you're sick. While this might not be what you're used to experiencing with a primary care provider, having an appointment before you have a care need ensures that they know you personally and understand your medical history and needs. That way, should an urgent need arise, they can make the best decision for your care. With first-time appointments available up to 90 minutes, you might find that your Everside provider can meet other needs you least expected, saving you time and money where it counts!

Four reasons to schedule your appointment now

Your provider gets the "big picture" of you.
Establishing care with your Everside Health provider helps form a baseline of your health. Your provider can determine your health risk factors and work with you to create an action plan for managing your health.

You get comprehensive, coordinated care.
Your Everside Health provider can take care of up to 80-90% of your healthcare needs. When outside care is needed, your provider will coordinate referrals and follow up care with specialists for you.

You get a trusted healthcare advocate.
The personal attention and extra time spent with your Everside Health provider can support your efforts in making all the right moves towards healthier living.

You may be able to save time and money.
Your Everside Health provider can help manage ongoing health concerns, which may add up to fewer sick days and lower healthcare costs.

Comprehensive care for the whole family

- Primary, preventive and 24/7 urgent care via phone
- Healthy lifestyle coaching
- Same- or next-day appointments for urgent needs
- Chronic condition management
- Care coordination
- Women's health
- Pediatrics, including well-child visits
- Onsite labs & prescriptions
- And many more services

Get the everside app or make an appointment today at
574-206-4156 or **members.eversidehealth.com**

everside HEALTH™

Employee Assistance Program
City of Elkhart - EAP Services

City of Elkhart, Indiana
the city with a heart

The City of Elkhart offers eligible employees and the family members living in their households an Employee Assistance Program with New Avenues, Inc. New Avenues offers confidential, short term, counseling through a network of licensed clinicians located close to your home or workplace. These trained professionals are ready to help you deal with family or work-life issues that may be causing your life to feel out of balance.

*All services are strictly confidential and at **no cost** to the employee or family members.*

Common Questions…

WHO IS ELIGIBLE?

- All active full-time employees and the family members living in their households.
- Dependents up to age 26, not living in the home of the employee, are eligible if on the employee's health insurance.
- Starts first date of active employment.
- Eligibility runs through the last day of employment.

WITH WHAT TYPES OF PROBLEMS CAN NEW AVENUES COUNSELORS HELP?

- Stress
- Anxiety
- Workplace Issues
- Personal Concerns
- Substance Abuse
- Grief
- Marriage/Family/Relationship problems

HOW MANY COUNSELING SESSIONS DO I HAVE?

- Sworn Police Officers have 12 sessions per employee family, per years.
- Firefighters, & 911 Operators have **8** sessions per employee family, per year.
- Other full-time employees have **4** sessions per employee family, per contract year.
- The contract year runs from **January 1st through December 31st**.

WHAT IF I NEED MORE SESSIONS?

Once you have used your EAP sessions, you may choose to continue services under the terms of your health plan benefit. You are responsible for fees incurred for additional sessions. (See your health plan SPD for a description of covered services). New Avenues makes every attempt to arrange your EAP sessions with a counselor who is in your health plan network so you may continue with the same person.

HOW DO I ACCESS MY FACE-TO-FACE EAP SESSIONS?

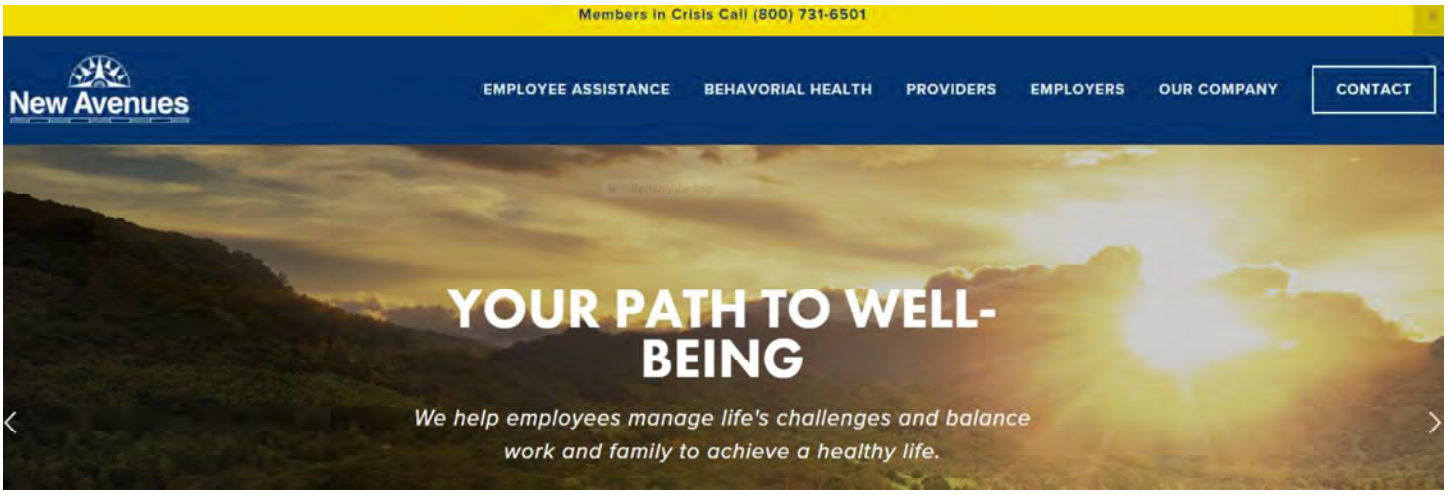
Just call New Avenues at: **800-731-6501 or 574-232-2131**. Select option **#2.** Services are strictly **confidential** and there is **no out-of-pocket cost** to you or to your family members.

Structured Telephonic Counseling

In addition to face-to-face counseling, New Avenues offers telephonic counseling as well as an array of online support services available 24/7. To access telephonic counseling call toll free 855-492-3625. For other work-life resources log-on to the New Avenues website at **http://www.NewAvenuesOnline.com** and click on Work-Life Resources.

New Avenues
Midwest Behavioral Health Network

New Avenues Toll Free # 800-731-6501



RESOURCES AVAILABLE at NewAvenuesOnLine.com ARE:

WORK-LIFE RESOURCE CENTER: Your **Password** is: **CompleteEAP.**

A web-based information center containing a wealth of articles, useful tips, interactive tools and links as well as access to Structured Telephonic Counseling (855-492-3625) offering live counselors that can be accessed 24/7 from the comfort of your home. Don't forget to sign up for the Savings Center, a free program where you will have access to savings of up to 25% on name-brand, everyday, and luxury items. Access the Work-Life Resource Center under the Employee Assistance tab on our home-page.

NEW AVENUES PROVIDER DIRECTORY:

A listing of licensed and credentialed counselors and therapists in the New Avenues EAP Network.

NEWS:

Articles on a variety of topics, such as Parenting, Child Care, Responsibility, Financial Assistance, that provide tips for improving the well-being of your professional and personal life. Don't miss the monthly featured articles on topics such as: Home Buying, Connecting with Your Loved Ones, Importance of Sleep, and Stress Relief Techniques.

ADDITIONAL RESOURCES AVAILABLE ARE:

MEDLINEplus Drug Information

A comprehensive guide to more than 9,000 prescription and over the counter medications.

PubMed

Click onto Health Information and then Medline/PubMed. PubMed is a service of the National Library of Medicine and provides access to over 11 million citations from MEDLINE and additional life science journals.

Facts for Families from the American Academy of Child & Adolescent Psychiatry

Specific to children and adolescents. This site offers information on a number of issues and diagnoses for this age group.

Surgeon General Reports

The U.S. Surgeon General's office has produced three landmark reports covering mental health topics. Reports on Mental Health, Suicide Prevention, Children's Mental Health, and Youth Violence can be accessed through this site.

National Council for Alcohol and Drug Abuse

Provides education, information, health and hope to the public.

To access these and other helpful links follow the *Resource* link under *Our Company*

New Avenues
Midwest Behavioral Health Network

Confidentiality Notice:

New Avenues and the clinical providers in its network are required by law to report any cases of suspected child abuse, elder abuse, or threats of physical harm to one's person or other individuals.

Toll Free: 800-731-6501

5/23/2018

W

PERF AT A GLANCE

PUBLIC EMPLOYEES' RETIREMENT FUND
HYBRID PLAN

	Defined Benefit	Defined Contribution (DC) Account
Vesting	**10 years** of PERF and/or TRF-covered service **8 years** for specified elected positions	**Immediate**
Contributions	**Employer pays 100 percent** ■ No member contributions ■ Employer contribution rate determined annually by INPRS board	**Mandatory 3 percent of gross wages paid by:** ■ Employer, or ■ Employee, or ■ Shared by employee and employer **Voluntary Contributions*** ■ Employee can elect to contribute additional monies ■ Employee's voluntary contributions are post-tax
Eligibility for Retirement Benefit Payment	■ Age 65 with 10 years of service ■ Age 60 with 15 years of service ■ At age 55 if age and creditable service total at least 85 ("Rule of 85") ■ Early retirement with reduced benefits between ages 50-59 with 15 years of service ■ Age 70 with 20 years of service** ■ Special provisions for certain elected officials	**Automatic eligibility for withdrawal once you separate from service***** ***Members separated from service may retire with PERF and continue to work in a non-INPRS covered position, as long as they meet age and service requirements.***
Eligibility for Disability Benefit Payment	■ Qualified for Social Security disability benefits and furnished proof of qualification ■ Received a salary from a PERF-covered position within 30 days of termination date ■ Minimum of five years of service	**Automatic eligibility for withdrawal if receiving a disability benefit**
Investment Options	**Members do not direct the investment of the Defined Benefit.**	**Choice of eight funds:** ■ Stable Value Fund ■ Money Market Fund ■ Fixed Income Fund ■ Large Cap Equity Index Fund ■ Small/Mid Cap Equity Fund ■ International Equity Fund ■ Inflation-Linked Fixed Income Fund ■ Target Date Funds

* Go to http://www.in.gov/inprs/perfmbrhandbooktwopartbenefits.htm for more on voluntary contributions.
**Actively employed members who have completed at least 20 years of service may apply for retirement benefits at age 70, remain actively employed and receive monthly benefits.
*** Certain restrictions may apply if you are vested in a pension benefit.

INPRS
INDIANA PUBLIC RETIREMENT SYSTEM

5/23/2018

PERF AT A GLANCE

PUBLIC EMPLOYEES' RETIREMENT FUND

	Defined Benefit	Defined Contribution (DC) Account
Account Statements	An estimate of benefits is available within one year of retirement eligibility. A benefits calculator is available on the website at www.inprs.in.gov.	Quarterly statements are provided online and/or mailed by PERF.
Withdrawals Before Retirement	**None** – members are not eligible for the Defined Benefit until they reach age and service requirements and separate from employment.	**Available only when disabled or separated from service** ■ May leave account invested in PERF, or receive a total distribution ■ No partial withdrawals ■ Rollover to qualified plan or other eligible retirement account
Income and Options at Retirement	**Monthly benefit for life** ■ Monthly amount determined by: 1. Age 2. Years of service 3. Average of annual compensation (Final Average Salary) based on 20 quarters 4. Multiplier of 1.1 percent (.011) ■ Taxable as ordinary income ■ Survivor designated options are available The monthly benefit amount is affected by the payment option election you make at retirement. ■ Any Cost of Living Adjustments (COLAs) must first be approved by the Indiana General Assembly. ■ Greater years of service and/or higher compensation can result in a larger benefit.	**Choices determine payments** ■ May choose monthly payment for lifetime benefit ■ May defer payment until age 70 1/2 ■ May choose direct payment or rollover distribution ■ Amount of distribution determined by account balance, taxes withheld, and distribution option chosen.
Beneficiaries	**Monthly payment** ■ Following death of retired member under applicable payment options ■ Following death of active member in limited circumstances	**Balance payment** ■ Receives total accumulated amount after death of active members or retired members who elected to defer payment ■ Receives remainder of accumulated amount per retirement payment options chosen by member

FOR YOUR BENEFIT

This handout is an overview of PERF's plan provisions. Complete details of the fund's provisions are available in the current member handbook. You may read it or print your own copy from the INPRS website at www.inprs.in.gov. You may also request a copy in writing or by calling our toll-free number, (844) GO-INPRS.

Keep your information current. Report any changes in your name, address or beneficiary choices directly to INPRS. This is NOT something your employer can do for you. To change your beneficiary, name or address information, visit www.inprs.in.gov.

Every attempt has been made to verify that the information in this publication is correct and up-to-date. Published content does not constitute legal advice. If a conflict arises between information contained in this publication and the law, the applicable law shall apply.

INDIANA PUBLIC RETIREMENT SYSTEM

VOLUNTARY POST-TAX CONTRIBUTIONS TO ANNUITY SAVINGS ACCOUNT

State Form 50895 (R8 / 8-15)
Approved by the State Board of Accounts, 2015

INDIANA PUBLIC RETIREMENT SYSTEM
Telephone: (888) 526-1687 (PERF-Toll-free)
(888) 286-3544 (TRF-Toll-free)
E-mail: questions@inprs.in.gov
Web site: www.inprs.in.gov

*This agency is requesting disclosure of Social Security numbers in accordance with Internal Revenue Code 3405; disclosure is mandatory and this form cannot be processed without it.

NOTE: If you are a member making voluntary after tax contributions, the tax basis on those contributions will generally be recovered over time pursuant to IRS tax basis recovery tables. Depending on certain factors you may recover part of your tax basis upfront in a lump sum. If you have questions about tax basis give us a call.

MEMBER FUND *(Choose one)*

☐ **PERF Hybrid or ASA Only** ☐ **Teachers' Retirement Fund**

INSTRUCTIONS

1. Type or print using black ink.
2. Return this completed form directly to your Payroll or Human Resources department. **DO NOT SEND TO INPRS.**
3. If you need further instruction call customer service, toll-free, at (888) 526-1687 (PERF) or (888) 286-3544 (TRF), Monday – Friday, 8 a.m.- 8 p.m. EST.
4. This form revokes any previous voluntary post-tax contribution directions you have made regarding your Annuity Savings Account (ASA).

MEMBER INFORMATION

Member's name		Social Security number	Pension ID (PID) number
Address	Telephone number with area code		Other telephone number with area code
City	State	ZIP Code	E-mail address

PAYROLL DEDUCTION ELECTION

- These contributions are limited to 10 percent of your compensation per pay period. The 10 percent maximum includes any additional voluntary contributions, pre-tax or post-tax, elected.
- These contributions do not affect your 3 percent mandatory employee contribution.
- These contributions are **post-tax and remain taxable income for income tax purposes.**
- This contribution level direction may be changed at any time in the future.

Select the additional percentage of compensation that you want to contribute to your ASA along with your 3 percent mandatory contribution. *(Check only one.)*

☐ 1% ☐ 2% ☐ 3% ☐ 4% ☐ 5% ☐ 6% ☐ 7% ☐ 8% ☐ 9% ☐ 10%

END PAYROLL DEDUCTION

☐ I hereby elect to **stop** making voluntary post-tax contributions to my Annuity Savings Account.

MEMBER AFFIDAVIT

I hereby revoke any previous voluntary post-tax contribution directions. I understand that these are voluntary post-tax contributions and remain taxable income for income tax purposes.

Member's signature	Date *(mm/dd/yyyy)*

Return this form to your Payroll or Human Resources Department. DO NOT send this form to INPRS. It will be returned to you and may delay processing of your election.

INSTRUCTIONS FOR

VOLUNTARY POST-TAX CONTRIBUTIONS TO ANNUITY SAVINGS ACCOUNT

State Form 50895

IMPORTANT

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4. This form revokes any previous voluntary post-tax contribution directions you have made regarding your Annuity Savings Account (ASA).

Entry field	Field description
MEMBER INFORMATION	
Member's name	Enter the complete name of the member.
Social Security number	Enter the member's Social Security number.
Pension ID (PID) number	Enter the member's Pension ID (PID) number.
Address, City, State, ZIP Code	Enter the member's street or mailing address.
Telephone number/Other telephone number	Enter telephone numbers including area codes for the member.
E-mail address	Enter the member's e-mail address, if applicable.
START VOLUNTARY CONTRIBUTIONS	
Start voluntary contributions	Check appropriate percentage for contribution.
STOP VOLUNTARY CONTRIBUTIONS	
Cease voluntary contributions	Check box to cease all voluntary contributions.
MEMBER AFFIDAVIT	
Member's signature	The member must sign and date this section of the form.
Date	The member must include the date the form was signed; format = mm/dd/yyyy.

HELPFUL INFORMATION			
	INPRS/PERF	**INTERNAL REVENUE SERVICE**	**INDIANA DEPARTMENT OF REVENUE**
Telephone numbers	(888) 526-1687 Toll-free	(800) 829-1040 Toll-free	(317) 233-4018 Indianapolis local
	INPRS/TRF	(800) 829-4477 TeleTax	(317) 232-2240 Tax questions
	(888) 286-3544 Toll-free	(800) 829-4059 TDD (hearing impaired)	(317) 233-4952 TDD (hearing impaired)
			(317) 233-2329 Fax
Web site	www.inprs.in.gov	www.irs.gov	www.in.gov/dor