BOARD OF PUBLIC WORKS AND SAFETY

RESOLUTION NO. 16-01

A RESOLUTION OF THE BOARD OF PUBLIC WORKS AND SAFETY OF THE CITY OF GREENWOOD ADOPTING EMPLOYEE HEALTH INSURANCE BENEFIT PLAN AND RELATED CONTRACTS FOR THE 2016-2017 POLICY YEAR

WHEREAS, the Board of Public Works and Safety of the City of Greenwood, Indiana (the "Board") recognizes that health insurance is an important benefit to the City's employees;

WHEREAS, health insurance represents a significant expenditure to the City's budget;

WHEREAS, the City's health insurance plan is renewed annual on April 1; and

WHEREAS, certain revisions and amendments are necessary to the City's Employee Health Insurance Benefit Plan due to changes in federal laws and regulations, market conditions, and budgetary reasons, including, but not limited to, the need to change third party administrators.

NOW THEREFORE, BE IT RESOLVED BY THE BOARD OF PUBLIC WORKS AND SAFETY OF THE CITY OF GREENWOOD, INDIANA THAT:

1. Pierre Fox of Regions Insurance, Inc. shall serve as broker of record for the City for its health insurance benefit plan for the 2016-2017 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

2. Anthem shall serve as the medical stop loss provider for the City for its health insurance benefit plan for the 2016-2017 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

3. Anthem Insurance Companies, Inc. shall serve as the third party administrator for the City for its health insurance benefit plan for the 2016-2017 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

4. Premiums for the 2016-2017 policy year shall be established as follows:

Category	Monthly Rate
Single	$75.35
Employee plus Spouse/Employee plus Children	$140.80
Family	$174.90

Additionally, a $20 monthly surcharge shall be applied to Employee plus Spouse accounts and Family accounts where the employee's spouse is employed full time at an employer who offers health insurance benefits.

5. The City's Employee Summary of Benefits is hereby approved in the form attached hereto as **Exhibit A**.

6. Delta Dental of Indiana shall serve as the provider for the City for its dental insurance benefit plan for the 2016-2017 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

7. Guardian VSP Choice Network shall serve as the provider for the City for its vision benefit plan for the 2016-2017 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

PASSED BY THE BOARD OF PUBLIC WORKS AND SAFETY OF GREENWOOD, INDIANA this 17th day of February, 2016, by a vote of 3 ayes, 0 nays.

BOARD OF PUBLIC WORKS AND SAFETY

Kevin Hoover

Michael Newbold

Shan Rutherford

ATTEST:

Amanda Leach, Board Clerk

Your Summary of Benefits

Anthem

City of Greenwood
Blue Access® (PPO)
Effective April 1, 2016

Covered Benefits	Network	Non-Network
Deductible (Single/Family) Plan Year	$500/$1,000	$2,000/$4,000
Out-of-Pocket Limit (Single/Family) Plan Year	$2,000/$4,000	$5,000/$10,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum:	$20/$35	30%
○ allergy injections (PCP and SCP)	$5	30%
○ allergy testing	20%	30%
○ MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products	20%	30%
Preventive Care Services Services included but not limited to:		
○ Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening, and Newborn Exams	NCS	30%
Emergency and Urgent Care		
Emergency Room Services	$200	$200
○ **facility/other covered services** (copayment waived if admitted)		
Urgent Care Center Services	$30	30%
○ MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products	20%	30%
○ Allergy injections	$5	30%
○ Allergy testing	20%	30%
Inpatient and Outpatient Professional Services Include, but are not limited to:	20%	30%
○ Medical Care visits), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia		
Blue 8.0		

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 60 days for skilled nursing facility	20%	30%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	30%
Other Outpatient Services (including but not limited to): • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services (Network/Non-Network combined) 100 visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics • Prosthetic Devices • Prosthetic Limbs • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% NCS 20%	30% NCS 20%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical therapy: 60 visits • Occupational therapy: 60 visits • Manipulation therapy: 24 visits • Speech therapy: 25 visits • Cardiac Rehabilitation: 36 visits • Pulmonary Rehabilitation: 20 visits	 $20/$35 20%	 30% 30%
Accidental Dental: Unlimited per occurrence (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	30%

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Behavioral Health Services **Mental Illness and Substance Abuse[2]:** • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	 20% 20% $20/$35 20%	 30%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage	NCS	50%
Prescription Drug Options: **Network Tier structure equals 1/2/3 (and 4, if applicable)** • **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip • **Home Delivery Service:** (90-day supply) Includes diabetic test strip Member may be responsible for additional cost when not selecting the available generic drug. **Medicare Rx - Wrap** **Specialty Medications** must be obtained via our Specialty Pharmacy network in order to receive network level benefits Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order.	 OTC $5 Allergy - Acid Reflux $10/$25/$40/$60 $20/$50/$80	 50%, min $60[5] Not covered
Lifetime Maximum Medical Surgical Treatment of Morbid Obesity	 Unlimited Not covered	 Unlimited Not covered

Notes:

- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services)
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance, including 0%. However, the deductible does not apply to Emergency Room Services where a copayment and coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.
- Dependent Age: to end of the month which the child attains age 26
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies. When the Office Visit cost share is a % coinsurance, deductible and coinsurance apply to allergy injections.
- NCS (No Cost Share) means no deductible/copayment/coinsurance up to the maximum allowable amount.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies.
- Benefit period = Plan Year
- Mammograms and colonoscopies (Diagnostic) are no copayment/coinsurance in Network office and outpatient facility settings.

Your Summary of Benefits

- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Elective abortions not covered unless otherwise noted in your Certificate of Coverage.

1 These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.
2 We encourage you to review the Schedule of Benefits for limitations.
3 Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

Precertification:
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.

Pre-existing Exclusion Period: none

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

This benefit overview is for illustrative purposes and some content may be pending Indiana Department of Insurance approval.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date February 17, 2016
Underwriting signature (if applicable)	Date

Employer Application for Administrative Services

Administered by: Anthem.

Please complete this form and use extra sheets of paper if necessary. For more information about Anthem, its products and services, visit **www.anthem.com.**
Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.

ANTHEM USE ONLY			
☑ New ☐ Termination ☐ Reclass	Group no.	State ☑ IN ☐ KY ☐ MO ☐ OH ☐ WI	Effective date (MM/DD/YYYY) 0 4 0 1 2 0 1 6	UGT no.

Section 1. EFFECTIVE DATE

Requested effective date: 0 4 0 1 2 0 1 6

Section 2. TYPE OF COVERAGE/PLAN. The benefits you have selected are outlined on the attached proposal, herein incorporated by reference.

Health coverage	Dental coverage	Vision coverage
☑ Blue Access® (PPO) ☐ Blue Access®Choice (PPO) (MO only) ☐ Anthem Essential℠ PPO ☐ Anthem Essential℠ Choice PPO (MO only) ☐ Anthem Essential℠ Select (MO only) ☐ Anthem Essential℠ POS (WI only) ☐ Blue Preferred® Plus (POS) ☐ Blue Preferred® (HMO) ☐ Blue Preferred® Select (MO only) ☐ Blue Preferred® ASO/EPO (OH only) ☐ Blue Priority® (HMO) (OH only - Exclusive Provider Organization or "EPO") ☐ Blue Priority® Plus (POS) (OH, WI only) ☐ Blue Traditional® (Indemnity) (IN, KY, OH only) ☐ Lumenos® HSA: ☐ PPO (IN/KY/OH/MO/WI) ☐ POS (WI only) ☐ Lumenos® HRA: ☐ PPO (IN/KY/OH/MO/WI) ☐ POS (WI only) ☐ Lumenos® HIA : ☐ PPO (IN/KY/OH/MO/WI) ☐ POS (WI only) ☐ Medicare Supplement (MO only) _____	☐ Dental Traditional (IN, OH only) ☐ Dental PPO ☐ Dental Blue® 100/200/300 ☐ Dental Blue® 100	☐ Vision

Section 3. MEDICARE PART D

Prescription drug benefits: ☐ Wrap ☐ Waiver ☐ Subsidy

If subsidy (CMS information needed)

Plan sponsor ID: _____ Application ID: _____ Unique benefit ID: _____

Section 4. EMPLOYER INFORMATION

Applicant (legal name of group)	Name of association (if applicable)
City of Greenwood	
Name and title of head of firm	**Name and title of administrative contact**
Mark Myers - Mayor	Lisa Bertram - Benefits Specialist

Home office address	City	State	ZIP code	County
300 S. Madison Ave	Greenwood	IN	4 6 1 4 3	Johnson

E-mail address	Phone no. (include area code)	Fax no. (include area code)
bertraml@greenwood.in.gov	317-887-5604	317-887-5868

Billing address and/or contact (if different from above)	Tax ID/FEIN (required)	No. of years in business
	35-6001050	100+

Standard industry code (SIC)	Type of business	Type of organization ☐ Partnership ☐ Corporation ☐ Sole Proprietorship ☐ Labor Union ☐ Trust ☑ Government Unit ☐ Other _____
9111	Municipality	

Group name
City of Greenwood

Section 4. EMPLOYER INFORMATION *(continued)*

Is any part of group subject to bargaining agreement? ☐ Yes ☑ No	Union name (attach copy of agreement)	Union no.	Union contract expiration date

Will bargaining agreement participants be considered eligible employees? ☐ Yes ☑ No

List all affiliates/subsidiaries/divisions (list names, locations, no. employed at each location.) Attach a separate page to show any separate billing addresses.

Names of affiliates/subsidiaries/divisions	Location	No. of employees per location

Total no. of employees residing/working outside of Home Office state	List no. of employees at each office location
0	

Name of current health carrier/third-party administrator

Advantage Health Solutions

Has your group been turned down for coverage in the last 12 months? ☐ Yes ☑ No	If yes, by whom, when, and why?
Will any entity, in addition to Anthem, provide health care benefits as part of the Group's employee benefit plan? ☑ Yes ☐ No	If yes, list entity and product(s) offered VSP - Vision Delta Dental - Dental
In the past 36 months, has the company or any affiliate entity filed for protection or operated under federal/state bankruptcy law (Chapter 11 or 7) or state receivership? ☐ Yes ☑ No	**In the past 36 months, has any creditor filed or threatened to file a petition requesting the company or any affiliated entity to be placed voluntarily into bankruptcy?** ☐ Yes ☑ No
Do you want Anthem to facilitate opening a Health Savings Account with Mellon ? ☐ Yes ☑ No	Is your group subject to COBRA? ☑ Yes ☐ No
Do you have a COBRA administrator? ☑ Yes ☐ No	**Do you want an Anthem affiliate to administer COBRA for your group?** ☐ Yes ☑ No If yes, please complete and sign the COBRA agreement.

List employees/dependent on Continuation of Coverage/COBRA	List of totally disabled employees and dependents	Name of persons in COBRA eligibility period

Section 5. ELIGIBILITY

No. of eligible employees (including those within their waiting period)	Total no. of employees (including part-time)
225	225

Eligible enrollees as of this plan's effective date will have coverage

☑ On group's effective date ☐ Same waiting period that applies to new persons or on group effective date, whichever is later

New eligible enrollees will become effective on

The day after	☒ 0	☐ 30	☐ 60	☐ 90	☐ 180 days of employment	*OR*
First billing date after	~~☑ 0 days~~	☐ 30 days	☐ 60 days	☐ 90 days	☐ 180 days	

Do any classes of employees have a different waiting period? ☐ Yes ☑ No	If yes, explain

Section 6. CONTRIBUTION REQUIREMENTS

Group contribution level for health care benefits

Employee	Employee/Spouse	Employee/Child	Employee/Family
90 %	91 %	91 %	92 %

Do any classes have a percentage of group contribution different than above? ☐ Yes ☑ No	If yes, explain

Group name
City of Greenwood

Section 7. Read this section carefully before signing. Please review your application for errors or omissions.

The employer and/or authorized representative hereby requests that Anthem Blue Cross and Blue Shield (hereinafter "Anthem" unless otherwise specified) administer certain health care benefits of employer's self-insured group health plan pursuant to the terms of the administrative services agreement. Employer, through an authorized representative, understands and agrees by payment of the required fees, to the following:

1. To comply with all terms and provisions of the administrative services agreement issued.
2. To make the health care benefits available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as agreed.
3. To maintain records and furnish to Anthem or their designated agent(s), any information required in connection with administration of the health care benefits.
4. To provide notice of any applicable conversion rights and rights to continue health care benefits under COBRA to eligible employees and eligible dependents.
5. That acceptance of this application may cancel any prior contract(s) or administrative services agreement with Anthem effective immediately preceding the effective date of the administration of health care benefits.
6. To pay Anthem by the due date stated in the administrative services agreement, the fees on behalf of each member enrolled for health care benefits, unless otherwise stated in the administrative services agreement between the parties, to submit applications of employees prior to their date of eligibility to keep all necessary records regarding membership, to assume responsibility for handling the COBRA and/or conversion process, if applicable.
7. That claims filed by or on behalf of members may, at Anthem's option, be suspended if fees are not timely received.
8. If applicable, Employer will receive on behalf of the members, all notices delivered by Anthem, and immediately forward such notices to persons involved, at their last known address.
9. That in order for Anthem to accept or decline this application, all the information requested on this application must be completed. In the event the application is not completed, Anthem, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application.
10. The fees calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem by the employer. Anthem reserves the right to review such fees upon receipt of all individual applications for employers' employees and to modify the fees, if the enrollment information so warrants.
11. The entire application for third-party administrative services has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.
12. All employees applying for benefits are employees of the employer and receive salary or wages documented on state and/or federal payroll reports.
13. The agreement is not in effect unless and until this application is accepted by Anthem, that agreement shall be evidenced by issuing an administrative services agreement to the employer, and an employee's health care benefits are not in effect unless and until the employee enrolls.
14. The employer acknowledges that it has signed the attached benefit proposals indicating the benefits requested.
15. The employer understands that when health care services are obtained outside the geographic area Anthem serves, claims for those services may be processed through the BlueCard program, as defined in the administrative services agreement. Employer understands and agrees (1) to pay certain fees and compensation to Anthem which Anthem's obligated under BlueCard to pay to the Host Blue, to the Blue Cross and Blue Shield Association, or to the BlueCard vendors, unless Anthem's contract obligations to employer requires those fees and compensation to be paid only by Anthem and (2) that fees and compensation under BlueCard may be revised from time to time without employer's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard.
16. The broker(s) listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem of this authorization is revoked.

Section 8. BROKER CERTIFICATION. I hereby certify that:

1. I have reviewed the attached employee and group applications and waivers for completeness and accuracy.
2. I have not completed any of the information contained in the applications except with the permission of the applicant and as noted by my initials on the application.
3. I have not signed any of the applications for the employer or any of its eligible employees.
4. I have advised the group that failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date or re-rating of the group's fee retroactive to the effective date. Health care benefits shall not be effective until Anthem reviews and accepts the application and the group receives a written notice and administrative services agreement from Anthem.

Broker signature	Broker name	Date
X	Jon Pierre Fox 	0 2 0 2 2 0 1 6

Address	City	State	ZIP code
9100 Keystone Crossing, Suite 550	Indianapolis	IN	46240

Broker ID no.	Tax ID no. to be paid	Broker phone no.	Anthem sales representative
AA5310011	71-0621654	317-581-3221	Terri Real

Agency name (if applicable)	General agency broker	Address
Regions Insurance		

Section 9. SIGNATURE

PLEASE ATTACH A CHECK FOR THE FIRST MONTH'S FEES, INCLUDING STOP LOSS PREMIUM, IF APPLICABLE.

Signature of authorized representative	Title	Location where signed	Date
X Mark W Mayo	Mayor	Greenwood, IN	0 2 2 3 2 0 1 6

ACCEPTED BY ANTHEM UNDERWRITING DEPARTMENT

Signature	Title	Date
X		

New Group Information Form

IMPORTANT: Please complete this form in it's entirety to ensuretimely set-up of your group.

Anthem BlueCross BlueShield

SECTION 1: GENERAL INFORMATION

Broker name Jon Pierre Fox/Regions Insurance	Phone no. 317-581-3221	Fax no. 855-452-1300	Email address pierre.fox@regions.com
Authorized signer Mark Myers	Phone no.	Fax no.	Email address myersm@greenwood.in.gov
Authorized HIPAA contact name Lisa Bertram	Phone no. 317-887-5604	Fax no. 317-887-5868	Email address bertraml@greenwood.in.gov
Additional contact name Krista Taggart	Phone no. 317-888-0494	Fax no.	Email address taggartk@greenwood.in.gov

SECTION 2: GROUP STRUCTURE DATA

Minimum hours required: 30

What is the waiting period for employees returning from leave/layoff?

☐ Waiting period waived if returning within: ☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☑ Same waiting period as a new hire

Member terminations: ☐ End of month ☑ Date employment terminates

Dependent terminations: ☐ End of month ☐ End of year ☐ Date of birth

Note: 51-99 Groups must choose End of Month for dependent terminations. 100+ Groups can choose any of the three options.

Do employees need to be in sub-groups for billing purposes? ☑ Yes ☐ No If yes, list the preferred structure below or send a separate sheet with description.

Subgroup structure			
Number (e.g., ex: 0001)	Name (e.g., Active, COBRA, etc.)	Number (e.g., ex: 0001)	Name (e.g., Active, COBRA, etc.)

SECTION 3: ANCILLARY PRODUCTS SOLD

Dental: ☐ Bundled with medical ☐ Not bundled ☐ Mixed benefits – different family indicator

Vision: ☐ Bundled with medical ☐ Not bundled ☐ Mixed benefits – different family indicator

Life: ☐ Products sold

SECTION 4: PERSONNEL COVERED

Active: ☑ Yes ☐ No

Hourly: ☑ Yes ☐ No

Salary: ☑ Yes ☐ No

COBRA: ☑ Yes ☐ No

Retiree: ☑ Yes ☐ No

If covering retirees, define retiree requirements:

SECTION 5: ADMINISTRATIVE INFORMATION

Are domestic partners covered? ☐ Yes ☑ No Prior carrier deductible? ☐ Yes ☑ No

Is sexual dysfunction covered? ☐ Yes ☑ No Out-of-pocket credit (one time) ☐ Yes ☑ No

Is morbid obesity covered? ☐ Yes ☑ No 4th Quarter carry over (100+ only) ☐ Yes ☑ No If yes, one time or on going?: _____

Will group have members in Minnesota, Arizona or Massachusetts? ☐ Yes ☑ No If yes, list state(s): _____

Enter employer contributions:	Medical	Dental	Vision	Life
Employees:	91 %	%	%	%
Dependents:	91 %	%	%	%

For 51-59 Groups only

Is the group a member of the Chamber of Commerce? ☐ Yes ☐ No

If so, which one?: _____ Chamber numbers: _____

Have Health and Wellness Buy-Up programs been purchased? ☐ Yes ☐ No

SECTION 6: ENROLLMENT SUBMISSION

A list of employees waiving coverage will be needed at the time of submission. Please provide a reason for waiving coverage (other coverage, no coverage etc.)

☐ Auto Enroll (100+)

☐ Applications

☑ IM01 (Excel spreadsheet)

SECTION 7: BILLING FORMAT

☐ Electronic Funds Transfer (complete form) ☑ ACH – Banking information will be provided (wire transfer) ☐ Monthly invoice

SECTION 8: PRESCRIPTION DRUG EDITS – ASO ONLY

☐ NDC block (Clinically equivalent alternatives) ☐ Remove ☐ Include

☐ Step therapies ☐ Remove ☐ Include

☐ Prior authorization ☐ Remove ☐ Include

SECTION 9: SIGNATURE – Required

Group signature	Print name	Title	Date (MM/DD/YYYY)
X Mark W Myers	Mark Myers	Mayor	

New Sale Disclosure Statement

Anthem. BlueCross BlueShield

As an underwriting consideration for final approval and pricing, you must disclose, to the best of your knowledge, any employees or their dependents who have medical conditions which have, or could reasonably result in, medical claims over $25,000. This disclosure would include most employees or their dependents that are currently in the hospital or will be in the hospital or who have other treatments resulting in claims over $25,000. This disclosure applies only to employee or dependent information that was not disclosed during the bid process.

SECTION 1: EMPLOYEE INFORMATION

Name	Employee/ Dependent	Birthdate	Sex	Diagnosis	Current status
	☐ Emp ☐ Dep		☐ M ☐ F		
	☐ Emp ☐ Dep		☐ M ☐ F		
	☐ Emp ☐ Dep		☐ M ☐ F		
	☐ Emp ☐ Dep		☐ M ☐ F		
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	☐ Emp ☐ Dep		☐ M ☐ F		

SECTION 2: EMPLOYER INFORMATION – Signature required

The employer named below, through its authorized officer and the broker/consultant/hired representative, hereby represents that the above list is true, complete and accurate to the best of their knowledge and belief, and that nothing has been knowingly or intentionally omitted. The employer and the broker/consultant/hired representative further agree that this information will be used to evaluate the pricing of the proposed coverage.

Employer name
City of Greenwood

Authorized officer signature	Print name	Title	Date
X [signature]	Mark Myers	Mayor	

SECTION 3: BROKER INFORMATION

Broker signature	Print name	Date
X	Jon Pierre Fox	0 2 0 2 2 0 1 6

Single-case Agreement
Addendum to Broker Agreement

Anthem BlueCross BlueShield

This Addendum ("Addendum") dated [ ], is agreed to by and between Anthem Blue Cross and Blue Shield ("Anthem") and Regions Insurance ("Broker"). This Addendum shall be effective as of [0 4 0 1 2 0 1 6] and supersedes and replaces any prior Addendum, Single-case Agreement, or other agreements regarding the compensation between the parties with respect to the Group provided in Section 3 below.

SECTION 1: EFFECT OF ADDENDUM

1.1 This Addendum constitutes an amendment and supplement to the Broker Agreement between Anthem and Broker in effect as of the date hereof (the "Broker Agreement") in accordance with the terms thereof, and supersedes and replaces the Commission portion of the Compensation Schedules attached to the Broker Agreement.

1.2 Except as expressly set forth herein, the Broker Agreement shall continue in full force and effect in accordance with its original terms, which terms shall also apply herein.

SECTION 2: TERM AND TERMINATION

2.1 This Addendum shall automatically renew annually, unless earlier terminated as provided herein.

2.2 Either party may terminate this Addendum with at least thirty (30) days advance written notice to the other party without cause ("Termination without Cause").

2.3 Anthem may terminate this Addendum effective upon mailing of written notice to Broker in the event of any breach of the terms hereof by Broker, or for any of the reasons set forth in the Broker Agreement, or any other provision thereof providing for termination for cause.

2.4 This Addendum shall terminate automatically and without notice in the event that the Broker Agreement is terminated pursuant to its terms.

SECTION 3: GROUP INFORMATION

3.1	Group name City of Greenwood		Group ID no.	
3.2	☑ New group ☐ Renewal	Renewal date	Association name	
3.3	Group location ☑ IN ☐ KY ☐ MO ☐ OH ☐ WI	Number of current health contracts 225		
3.4	Broker to be paid Regions Insurance	Commission split 100 %	Broker Tax ID no. 71-0621654	Broker code AA5310011
3.5	Broker to be paid	Commission split %	Broker Tax ID no.	Broker code

SECTION 4: COMMISSION

Please complete Options 1, 2, 3 or 4 below:

- Complete Option 1 if per capita rate varies by lines of business
- Complete Option 4 if commission is to be paid on a percent of premium
- Complete all lines of business fields and use N/A if line of business does not apply

1.	Per Capita Commission Rate per Subscriber Per Month (PSPM): Health $0 Dental $_____ Vision $_____ Life $_____ Other: _____ $_____ Other: _____ $_____
2.	Per Capita Commission Rate for Administrative Service Only (ASO) Group (PSPM): Health $0 + _____% Stop Loss = $_____ PSPM Dental $_____ Vision $_____ Other: _____ $_____
3.	Flat Commission Rate for ASO Group of $0 per month
4.	Percent of Premium: Medical: 0 % Dental: _____% Vision: _____% Life: _____% Other: _____ _____%

Note: If a Commission split is indicated in Section 3 of this Addendum, then the rate(s) indicated in Section 4 will be split accordingly.

SECTION 5: ACCEPTANCE OF ADDENDUM – Signatures required

Anthem may modify or amend this Addendum upon thirty (30) days' written notice to Broker.

By executing this Addendum below, the Broker attests that all compensation requested by this Addendum has been fully disclosed by the Broker to the Group. Further, by executing this Addendum, the parties agree to the terms hereof.

Anthem Blue Cross and Blue Shield		
Regional Vice President or Regional Sales Director signature **X**	Name	Date
Sales Representative		
Sales representative signature **X**	Name	Date
Broker One		
Broker one signature **X**	Name Jon Pierre Fox	Date
Broker Two		
Broker two signature **X**	Name	Date
Group Representative		

Group name City of Greenwood, group no. _____, through its authorized representative hereby certifies that Broker name(s) Regions Insurance is authorized to receive commission as described in Section 4.

Group representative signature **X** Mark Myers	Name Mark Myers, Mayor	Date
Underwriting Approval		
Underwriter signature **X**	Name	Date

How to properly complete and submit a Single-case Agreement

Please note that ALL applicable information needs to be completed on the Single-case Agreement (SCA) in order to be valid.

Completing Page 1

A. All appropriate blanks appearing at the top of this page before Section 1 shall be completed including the SCA origin date, the Broker entering into the SCA, and the effective date of SCA.

B. Section 3 contains the information pertinent to the group in which the SCA is being submitted along with the Broker who is to receive commissions for the group listed. All information should be provided and in the event that information is not applicable, please indicate N/A in the appropriate area.

C. If information in Section 3 is not complete or if the Broker listed does not meet all Licensing & Contracting guidelines, the SCA will not be accepted and will need to be re-submitted once additional information is provided or guidelines have been met.

D. Agents who assign commission to an agency should indicate the agency and their corresponding agent code in order to ensure commissions are paid correctly to the appropriate party.

Completing Section 4

A. The appropriate commission line is to be used dependent on the type of commission to be paid. Multiple lines should not be used.

B. The specific commission rate to be paid on all lines of business need to be indicated on the SCA, even if one or more lines of business are deemed to be standard. "Standard" is not an appropriate answer as multiple "standard" rates exist dependent upon state and size of business.

C. Per subscriber per month (PSPM) commissions are to be paid based on a flat dollar amount per line of business. If there is a line of business not listed, please use the Other category to define the line of business and PSPM commission rate.

D. For an Administrative Service Only (ASO) group, if the commission rate includes a percentage of stop loss premium, the stop loss premium needs to be converted to a PSPM amount and the total PSPM rate should be indicated. If stop loss premium is not included in the commission rate, the stop loss percentage should be 0%.

E. **Attention Sales and Underwriting:** For all ASO and National groups, Funding Documents are required to be submitted with the SCA. The commission section of the Funding Document should clearly show all commissions to be paid with all percentages converted to PSPM rates.

F. If a flat monthly dollar amount is to paid on an ASO group, indicate the monthly amount to be paid in Option 3.

G. Percent of premium commissions are not applicable for Indiana, Kentucky, or Ohio business. Effective April 2003, all Ohio commissions transitioned from percent of premium to per subscriber per month or per capita. Effective April 2004, all Indiana and Kentucky commissions transitioned from percent of premium to per capita.

H. **Missouri and Wisconsin business only:** If a percent of premium is to be paid, all lines of business to be paid need to be populated with the specific percentage to be paid. If there is a line of business not listed, please use the Other category to define the line of business and the commission percentage.

Completing Section 5

A. All SCAs require internal signatures by a Regional Vice President or Regional Sales Director of the state in which the policy is enforced, as well as the Sales Representative and Underwriter for the particular group.

B. All SCAs require Broker's signature by all Brokers listed to be paid to acknowledge that the information listed on the SCA is correct.

C. All SCAs require the group signature if any of the listed commission rates for any line of business is above the standard commission rate for the state and segment of business that the group is categorized.

D. If a flat monthly dollar amount is indicated for an ASO group, the group signature is required if the monthly amount divided by the number of subscribers for the group equals a commission rate above the standard commission rate.

Submitting Single-case Agreements

A. All SCAs for new or renewal business shall be submitted to the following Sales Compensation mailbox: Sales.Comp.Central.Region.Internal.Inquiries@anthem.com

B. While the existence of a Single-case Agreement is a prerequisite to any non-standard payment obligation by Company, the Single-case Agreement will only be honored if complete and properly submitted.

C. An SCA shall only be submitted when at least one line of business is to be paid at a non-standard commission rate. If a group is to be NET of commission, meaning no commissions are to be paid, an SCA is not needed.

D. Email notification of a group being NET of commission shall be forwarded to above shared mailbox by appropriate Sales Representative or Underwriter.

Medicare Secondary Payer
Employer Status Form

Anthem BlueCross BlueShield

Complete this form to assist with compliance with the Medicare Secondary Payer regulations of the Centers for Medicare and Medicaid Services (CMS). You may want to check with your legal counsel to confirm the Medicare Secondary Payer requirements.

SECTION 1: GROUP INFORMATION

Group name			Group ID no.
City of Greenwood			
Group contact name	**Phone no.**	**Fax no.**	**Email address**
Lisa Bertram	317-887-5604	317-887-5868	bertraml@greenwood.in.gov

The business or organization ("Group") named above ☐ **does NOT** ☑ **does** have 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year, and ☐ **does NOT** ☑ **does** have 100 or more employees on 50 percent or more of its regular business days during the preceding calendar year.

"Employees" include (even if they are not eligible for Anthem group health plan benefits):

- Part-time, full-time and leased employees
- Persons not working but receiving payments normally subject to FICA taxes, such as persons on disability for the first six months

If the Group is part of a controlled group of employers under IRC Sec. 53(a) and (b) or an affiliated service under IRC Sec. 414(m), then all employees in the aggregated group of employers must be included in the count of the Groups employees.

The Group agrees to notify Anthem Blue Cross and Blue Shield as soon as the statement above is no longer true.

The Group employed how many employees? 225 As of what date? 0 2 0 1 2 0 1 6

If this form states a change in the category (i.e., under 20, over 20 or over 100 employees) for the Group, then a copy of the business' or organization's latest wage and tax statement must be attached and returned with this form.

SECTION 2: SIGNATURE – Required

I certify that the information provided above is true to the best of my knowledge and belief.

Group administrator signature	Print name	Title	Date
X	Mark Myers	Mayor	

Stop Loss Policy Application

Anthem BlueCross BlueShield

SECTION 1: COMPANY INFORMATION

Legal company name	Phone no.	Policy effective date
City of Greenwood	317-887-5604	0 4 0 1 2 0 1 6

Street address	City	State	ZIP code
300 S Madison Ave	Greenwood	IN	46143

Group Administrator – Future correspondence contact	Title
Lisa Bertram	Benefits Specialist

Phone no.	Fax no.	Email address
317-887-5604	317-557-5868	bertraml@greenwood.in.gov

Type of coverage for which stop loss is sought: ☑ Medical ☑ Prescription drug card ☐ Dental ☐ Vision

Stop loss policies provide insurance coverage only for the purchaser of the policy for the purchaser's liability under a group health plan it sponsors. Anthem has no liability to group participants or beneficiaries under the health care plan by virtue of any stop loss policy.

SECTION 2: PARTICIPATION

Total number of eligible employees: 225

Eligible employee is defined as a person who is determined to be eligible to elect coverage under the group health plan by the Applicant under applicable provisions of its group health plan. Plan eligibility provisions, including changes thereto, must be approved in advance by Anthem. For the purposes of this application, the term group health plan means that portion of the employee welfare benefits plan of the Applicant under which Anthem or an affiliate of Anthem administers health plan benefits.

SECTION 3: BROKER/AGENT – If applicable

Name	Agency name	Phone no.
Jon Pierre Fox	Regions Insurance	317-581-3221

Street address	City	State	ZIP code
9100 Keystone Crossing, Suite 550	Indianapolis	IN	46240

I hereby certify that all the information in the Application is correct to the best of my knowledge, and I know nothing unfavorable about this group. I have complied with the underwriting rules and regulations and have explained in detail the coverage to the group.

Agent signature	Insurance agent license ID no.	Date
X		

SECTION 4: CERTIFICATION – Signature required

By signing below, the Applicant certifies that the information on this form is correct to the best of its knowledge and agrees to:

1. Promptly remit the appropriate premium by the payment date in accordance with the policy issued and the administrative service agreement through which the premium may be collected;
2. Provide every eligible employee an opportunity to enroll in the group health plan when he or she becomes eligible (only eligible employees, as defined above, may be enrolled);
3. Maintain enrollment in the group health plan at or above the minimum requirement of 75% of net eligible employees;
4. Maintain the minimum employer contribution requirement of 50% of the employee only rate established by the group health plan;
5. Fully abide by the terms of the policy issued by Anthem pursuant hereto as though the Applicant's authorized representatives had duly executed said documents on its behalf.

Further, the Applicant understands that failure to comply with the agreed-upon responsibilities, as listed above, will give Anthem the right to terminate the policy in accordance with its terms.

Signature of authorized company official	Name	Title	Date
X Mark Myers	Mark Myers	Mayor	

ASO Contact Information Request
Facets

Anthem BlueCross BlueShield

Group contact information

	Name	Email address	Phone no.	Fax no.
1.	Krista Taggart	taggartk@greenwood.in.gov	317-888-0494	
2.	Lisa Bertram	bertraml@greenwood.in.gov	317-887-5604	
3.				
4.				
5.				
6.				
7.				
8.				

Weekly reports

Report name	Format	Purpose	PHI?	Do you want to see PHI?	Group contact(s) to receive which report. Please place a comma between names if more than one.
Anthem Invoice	PDF	Invoiced amount due	NA		
INV0100 ...	Excel	Claim summary	NA		
OISK ...	Excel	Weekly claim detail	Yes	☐Y ☐N	
INV0300 ...	Excel	Varied billing report misc items	Yes	☐Y ☐N	
STL0100 ...	Excel	Weekly specific stoploss activity	Yes	☐Y ☐N	
STL0101 ...	Excel	Weekly specific stoploss warning	Yes	☐Y ☐N	
CAP0300	Excel	PC2 fee detail	Yes	☐Y ☐N	
CAP0400	Excel	PC2 fee summary	NA		
ITM0100	Excel	Capitation fee	Yes	☐Y ☐N	

Monthly reports

Report name	Format	Purpose	PHI?	Do you want to see PHI?	Group contact(s) to receive which report. Please place a comma between names if more than one.
STL0200 ...	Excel	Monthly aggregate SL	NA		
ENR0200* ...	Excel	Monthly membership detail	Yes	☐Y ☐N	
ENR0201* ...	Excel	Monthly retroactivity details	Yes	☐Y ☐N	
INV0200* ...	Excel	Monthly membership summary	NA		

*Reports will not be sent if group self reports their administrative fees.

The above reports are our standard package and some reports may not pertain to each customer as it depends on the customer's elections. Please disregard these if they do not pertain to you.

The standard process is to send the weekly reports via email; secure email if PHI is to be received. Once a month when the administrative fees are invoiced, the weekly reports will be sent along with the monthly reports.

NPD Standard Procedures:
Creation of Linkage Between the NY HCRA Pools and a Client

Nat'l Pools Desk administered TPAs – 6/08, 3rd Edition

Welcome to the wonderful world of Pools. Following is a concise discussion of the Nat'l Pools Desk's (NPD) standard procedure for creation of a self-insured (ASO) client employer's third party administrator (TPA) association for the New York Health Care Reform Act (HCRA) Public Goods Pool. *[TPA association here includes the entire election process when for an unelected ASO. Fully insured clients may not elect.]* HCRA is a NY taxing authority (pure and simple), established by NY statute and administered on the State's behalf by Excellus BCBS. *[The word "Pool" in this context is a euphemism for tax. The acronym "TPA" means a third party administrator officially authorized by HCRA to report on behalf of ASO electors—NO other industry TPA definitions hold here.]* There is no attempt herein to standardize the procedures (or lack of them) employed by other TPAs, Anthem's or not. While payment of **NY resident MEMBERSHIP assessments** by "Blue" insurers on a client's behalf is frequently not dependent on the existence of a formal connection between an ASO and a TPA, a HCRA-accepted TPA association is the ONLY way a TPA may report **non-ITS, NY provider CLAIMS surcharges** on an incurring ASO group employer's behalf...

1. HCRA payment responsibility legally always remains with a client even though it may authorize an agent TPA to report on its behalf. As always, taxes must be paid when due, and client ignorance of the law is never an excuse. Failure to choose to elect OR properly pay HCRA taxes in a timely manner may result in assessment of additional penalties discussed below, plus interest. It's NY law. New for 2007 and beyond, all employers with group insurance may be subject to HCRA's expanded audit program on demand.
2. Unless a client has a valid business reason not to, NPD recommends that every ASO, either National or local, and regardless of actual operational proximity to NY, create appropriate TPA association(s) immediately, before incurrence of claims in NY by visitors, family members, students, or those requiring specialized care available in that state.
3. A diminutive amount of initial paperwork is a small price to pay to potentially eliminate Pools' unelected tax penalties and hassles. When requested by NPD after initial research, all required info should be digitally entered into a *current* Excel worksheet provided (preferred), or written and then scanned/faxed. While ALL requested info (including potential D/B/As) must be provided before an NPD client review can result in customized paperwork, the only information typically required of an employer is...
    - **Full legal (or existing elector) firm name**.
    - **Federal EIN** corresponding with the above name.
    - Initial, continuous, **Anthem ASO activation date**, plus any ASO restart dates.
    - **Corporate parent/ownership** association, if any *[to allow research on the entire company's election status and creation of advice on preferred action(s).]*
    - **Funding arrangement** and minimal contract detail.
    - **Group/firm/case number(s) and data platform name(s)**.
    - Firm's **current designated HCRA contact** information.
    - Names of potentially-necessary **D/B/As** as simple alternatives to the separate election process.
    - The new Anthem TPA's **status, either "replacement" or "additional."**

    And, if the employer is confirmed already an elector AND the new Anthem TPA is NOT designated to be an "additional" TPA,
    - **Prior TPA name, end-of-runout date** and (optional) FEIN.

Why does HCRA paperwork exist as it does?

The entire point of HCRA "election" is to **provide NY providers with a public website for their research, containing current elector status to determine whether or not to attach mandated UNELECTED PENALTIES** of an additional up-to-50% tax on PAID claims amounts. Big money! While Anthem claims activity is insulated from penalty attachment by the BCBSA ITS system most Anthem business utilizes, non-Blue carriers can't use ITS. Consequently, to properly service an ASO client, Anthem should review the practices of ALL current carriers providing a client with ASO institutional claims coverage, not just our own business, to help it **minimize the client's total tax burden**.

NY providers research the EMPLOYER name appearing on an incurring member's ID card. If they locate either a valid HCRA website elector listing under that name, or a D/B/A *[doing business as]* pointing to it, NO penalty is assessed.

NPD Standard Procedures:
Creation of Linkage Between the NY HCRA Pools and a Client

Nat'l Pools Desk administered TPAs – 6/08, 3rd Edition

But if an election is invalid (revoked, cancelled, etc), or an ID's employer name doesn't match located electors and D/B/A names (or the name can't be located because of spelling issues, employer name change, or other differences between legal names and elector/D/B/A names, etc), the full unelected penalty, partly determined by the provider's NY geographical region, may be immediately attached to non-Blue claims and payable, sometimes invisibly. There is no such thing as retroactive elimination of provider-assessed penalties.

The procedure.

The appropriate forms and/or letter drafts to properly complete an individual ASO client's TPA association, the prelude to HCRA reporting on its behalf by a TPA, are **CUSTOM created according to the individual client's circumstances**. While other TPAs do much less, NPD finds attention to detail right off the bat results in uniform, timely HCRA acceptance of submitted paperwork THE FIRST TIME. Emailed notice to and from NPD, rather than phoned advice, fax, etc, is always preferred as a paper trail is automatically generated.

1. **THE FIRST STEP IS EMAILED NOTICE TO NPD FROM SALES, IMPLEMENTATION, ETC, THAT A CLIENT MAY REQUIRE HCRA ACTION**. Sales, etc, always STARTS the name identification process as early as possible by **emailing** the Nat'l Pools Desk (NPD). Provided should be (researchable) **full legal names** of the new or pre-existing ASO client, and **the names of any KNOWN parent corporations and/or (potentially) separately-elected divisions/subsidiaries, and D/B/As**, as well. While legal names may end up not being used for election or D/B/A creation, they surely provide the best start for research of undiscovered, existing associations. Existing client name variations of any type, missed during NPD research, will likely create an unintended void in total client action OR cause complete HCRA rejection later on. Always include the Sales Account Manager's, etc, recipient name for return contact.

   Known D/B/As provided now will be researched, but potential new D/B/A names should be provided later by Sales as part of the actual worksheet, for additional NPD review/research then. If the possibility exists that any name other than the primary corporate parent company being TPA-associated, including legal acronyms (abbreviations), etc, may appear on a member's ID card (Anthem's or not), each and every such name should be addressed by NPD.

   It is perfectly legal for an ASO to choose to NOT ELECT to HCRA, however, **the firm must then SELF-REPORT all HCRA taxes due**—there is virtually NO taxing EXEMPTION for any unelected client, be it distant from NY, nonprofit, or anything else. Of course, UNELECTED PENALTIES are likely to be regularly due for taxable, non-ITS-processed claims. *[An unelected ASO cannot legally employ any TPA to report on its behalf. NPD provides no data for any client's use for self-reporting.]*

   Remember, the point here is to eventually **IDENTIFY EVERY EXISTING EMPLOYER NAME (INCLUDING SPELLING AND OTHER VARIATIONS) APPEARING ON ANY CLIENT MEMBER ID CARD FOR ANY ACTIVE CARRIER, NOT JUST ANTHEM, to be researched. It's always the employer name appearing on a member ID card that rules for NY providers, not a firm's legal or common-use alternatives.** If, as is usual, Sales doesn't know a client's complete current HCRA election and/or TPA association status with Anthem, OR its D/B/A existence status, always assume none exists and ask for complete review by completing this first step. For a diversified client, existing elector and D/B/A name(s) may already match those on ALL of its member ID cards, but NPD will bet they don't. Only discovery and research of its complete set of employer names will tell. *[Note: an elected client itself frequently has little idea of its own HCRA situation even though IT is the party that has sworn to follow HCRA rules. An unelected client would be expected to be even worse. And brokers may be knowledgeable, or not, or somewhere in between.* ***Always rely on Anthem TPAs for HCRA advice, not outsiders claiming expertise.]***

2. **NPD COMPLETES INITIAL RESEARCH** and attaches the result (and any comments) to a standard cover email with instructions to Sales, along with the most recent version of the blank worksheet, ready for Sales' completion. Aside from a client's existing elector and D/B/A name(s) and their status, the identified website entries provide identification for Sales of the **existing**, mandatory, designated HCRA contact person, for comparison with current reality and aids any intended revision.

NPD Standard Procedures:
Creation of Linkage Between the NY HCRA Pools and a Client

Nat'l Pools Desk administered TPAs – 6/08, 3rd Edition

The object of our collective labors is to correct any existing client HCRA elector inadequacies. *[Fairly complete instructions are contained in both the worksheet itself and its cover email—don't rely on memory—use the instructions and don't delete them until done.]*

3. **SALES, ETC, [USUALLY NOT THE CLIENT] COMPLETES THE WORKSHEET**, usually 10 questions per client/elector, sometimes less, and returns it by email to NPD for processing. Of course the client or broker should be consulted by Sales as necessary during this process, but NPD has found **worksheet accuracy and completeness are consistently higher when accomplished by Anthem associates**. Be sure all parts of the required questions have been completely answered, as we'll just have to come back again & again until we have what we need, wasting gobs of everyone's time. In most cases, NOTHING may be filed until all required/requested info has been received. *[The Excel version provided is always preferred for return, as handwriting frequently requires wasteful confirmation.]*

4. **NPD COMPLETES INVESTIGATION & ANALYSIS AS INDICATED BY WORKSHEET RESPONSES, PRE-POPULATES ALL FORMS, DRAFT LETTERS, ETC**. Based on the worksheet responses, NPD will determine WHICH Anthem TPA(s) a client needs association with. NPD provides the pre-populated, signature-ready forms, etc, to Sales, etc, for transmittal to a client for execution (signature, etc).

   Note: individual state data platform, **JAA** and/or **Lumenos** clients being partially or fully migrated to any other Anthem data platform may require multiple TPA arrangements, not just NPD's or another single TPA. A client determined to be either exclusively or co-associated with any non-NPD TPA will be so identified. NPD analyzes which Anthem TPA(s) should associate with a specific client and includes that determination in the form(s), even if not for an NPD-reported TPA.

5. **CLIENT OR SALES RETURNS SIGNED DOCUMENTS TO NPD** (or other designated TPA) for filing. No one, (client, broker, Anthem Sales, or another TPA) should ever submit un-reviewed, NPD-associated filings directly to HCRA without notice to NPD, without the expectation that errors and omissions may well exist in the filed documents and that an excluded NPD will have no knowledge of what client reports to file, when, and for whom.

6. **NPD COMBINES THE CLIENT-SIGNED DOCUMENTS WITH REQUIRED TPA FORMS AND ANY RETRO REPORTS DUE, AND SUBMITS THE ENTIRE FILING TO HCRA** on behalf of client. **NPD provides copy of completed paper filing** to designated Sales account exec, etc. *[Several classes of documents must be eFiled with HCRA, not paper filed—in these cases no documentation useful for Sales exists.]*

7. Of course, from-time-to-time **EMERGENCY NPD SERVICES WILL BE REQUIRED, in case of revocation, delinquency, rejection, etc**. This is our stock-in-trade. Don't hesitate, ACT—who ya gonna call, **NPD**.

You'll notice that, per NPD standard procedure, no one but NPD ever prepares or provides any forms other than the worksheet. That's because without our information banks and daily hands-on experience, no one has a better chance of choosing the correct procedures, forms and support than does NPD, occasionally including HCRA itself. Further, Sales has more important things to do than trying to create HCRA-acceptable documents from unfamiliar blanks. So we provide everything, signature-ready. And NPD itself now has responsibility for reporting some 800 ASOs across Anthemland, very, very few of which resulted in initial HCRA rejection, and those few were client provided errors.

Add'l topics.

- **TRAINING IS AVAILABLE ON DEMAND**. Request organizational Pools orientation as soon as possible by email or phone.
- **NPD'S ADDRESS**. NPD has a shared email address ["PoolsDesk@anthem.com"], or associates Dick Gelgauda [Richard.Gelgauda@anthem.com] and Naveen Jaganathan [Naveen.Jaganathan@wellpoint.com] may be emailed directly appropriately-named attachment. Both multiple client lists and single client research requests are welcome.
- **THERE ARE NO SILLY OR UNNECESSARY POOLS QUESTIONS**. Never hesitate to call or email a question as soon an issue arises.

State Tax Registration Worksheet

For ASO only

Preliminary INTERNAL Anthem information gathering – NOT an election document for client signature.

Complete all pertinent questions. Universal-all purpose.

Client status: ☑ New business ☐ Existing business ☐ Data migration ☐ Acquisition

Other names: Potentially-separate reporters subsidiaries, mergers and acquisitions, parent, etc. must be identified to the National Pools Desk (NPD) to insure proper continued reporting, consolidation with other reporters, or de-activation occurences. NPD will gladly research all such issues and advise. Ask NPD immediately for advice, or provide full legal names of suspected self-reporters as email text, in question 10 below, etc.

1.	Client full legal name City of Greenwood	Federal EIN – must correspond with name 35-6001050
2.	Anthem ASO activation/migration date 4/1/2016	
3.	Is client owned by another entity? ☐ Yes ☑ No	If yes, legal name
4.	Funding type ☑ ASO ☐ Other: _____	

5. Anthem data information	1	2	3	4
Group/case/firm number				
Data platform name				

6. Designated (routine) taxing authority/public contact person

☑ No contact change ☐ Confirmed as new designated contact

Contact last name	First name	M.I.	Name and phone appear on HCRA website
Bertram	Lisa		

Phone	Title	Confirmed email address
317-887-5604	Benefits Specialist	bertraml@greenwood.in.gov

Mailing street address	City	State	ZIP code
300 S Madison Ave	Greenwood	IN	46143

7. New TPA status

☑ New TPA is replacing one or more previously-existing TPA(s) ☐ New TPA will be an additional TPA ☐ No current TPA

8. Previous or migration source TPA

Previous TPA name	Runout end date for previous TPA	Previous TPA's FEIN (optional)
Advantage Health Solutions		

9. Member ID card D/B/As

☐ YES! Other valid ID Card employer name(s) exist for one or more current healthcare insurers.
☐ NO! Except for question one firm name above, no other client ID Card employer names exist for any insurer, so no D/B/A(s) necessary.

General rule: The employer name appearing on a member ID card should exactly match either the official elector name or an established D/B/A name, or the client may risk assessment of unelected penalties. Even the presence of a simple "..., Inc." or not difference may cause penalty. Ask NPD if unsure.

10. Explanations, detail, items for research, migration details, changes, questions, discussion, etc.

11. For migrations only

Is this a partial or complete migration from one WellPoint data platform to another? ☐ Partial ☐ Complete

Primary Anthem sales contact	Phone no.
Terri Real	

Return by email or interoffice:
National Pools Desk
Mailpoint OH0103-A002
Anthem, 4361 Irwin-Simpson Road, Mason, OH 45040

Contact for additional info:
Phone: 513-336-2146
Email: poolsdesk@anthem.com

Group Health Plan Business Associate Agreement

This Business Associate Agreement ("Agreement") is effective as of 04/01/2016 and is made among Business Associate, and the Group Health Plan ("Plan"), and the Employer ("Employer") named on the signature page of this Agreement.

WITNESSETH AS FOLLOWS:

WHEREAS, Employer has established and maintains a plan of health care benefits which is administered by the Employer or its designee as an employee welfare benefit plan as defined by Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA");

WHEREAS, Employer has retained Business Associate to provide certain claims administrative services with respect to the Plan which are described and set forth in a separate Administrative Services Agreement among those parties ("ASO Agreement"), as amended from time to time;

WHEREAS, Employer is authorized to enter into this agreement on behalf of Plan;

WHEREAS, the parties to this Agreement desire to establish the terms under which Business Associate may use or disclose Protected Health Information (as defined herein) such that the Plan may comply with applicable requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-164) ("HIPAA Privacy Regulation" and/or "HIPAA Security Regulation") and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act"), that are applicable to business associates, along with any guidance and/or regulations issued by the U.S. Department of Health and Human Services.

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, the Plan, Employer and Business Associate hereby agree as follows:

PART 1—BUSINESS ASSOCIATE'S RESPONSIBILITIES

I. PRIVACY OF PROTECTED HEALTH INFORMATION

A. Confidentiality of Protected Health Information

Except as permitted or required by this Agreement, Business Associate will not use or disclose Protected Health Information without the authorization of the Individual who is the subject of such information or as required by law.

B. Prohibition on Non-Permitted Use or Disclosure

Business Associate will neither use nor disclose Individuals' Protected Health Information except (1) as permitted or required by this Agreement, or any other agreement between the parties, (2) as permitted in writing by the Plan or its Plan administrator, (3) as authorized by Individuals, or (4) as required by law.

C. Permitted Uses and Disclosures

Business Associate is permitted to use or disclose Individuals' Protected Health Information as follows:

1. Functions and Activities on Plan's Behalf

Business Associate will be permitted to use and disclose Individuals' Protected Health Information (a) for the management, operation and administration of the Plan, (b) for the services set forth in the ASO Agreement, which include (but are not limited to) Treatment, Payment activities, and/or Health Care Operations as these terms are defined in this Agreement and 45 Code of Federal Regulations § 164.501, and (c) as otherwise required to perform its obligations under this Agreement and the ASO Agreement, or any other agreement between the parties

provided that such use or disclosure would not violate the HIPAA Privacy or Security Regulations if done by the Plan and the HITECH Act,

2. **Business Associate's Own Management and Administration**

a. **Protected Health Information Use**
Business Associate may use Individuals' Protected Health Information as necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities.

b. **Protected Health Information Disclosure**
Business Associate may disclose Individuals' Protected Health Information as necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities only (i) if the disclosure is required by law, or (ii) if before the disclosure, Business Associate obtains from the entity to which the disclosure is to be made reasonable assurance, evidenced by written contract, that the entity will (x) hold Individuals' Protected Health Information in confidence, (y) use or further disclose Individuals' Protected Health Information only for the purposes for which Business Associate disclosed it to the entity or as required by law; and (z) notify Business Associate of any instance of which the entity becomes aware in which the confidentiality of any Individuals' Protected Health Information was breached.

3. **Miscellaneous Functions and Activities**

a. **Protected Health Information Use**
Business Associate may use Individuals' Protected Health Information as necessary for Business Associate to perform Data Aggregation services, and to create Deidentified Information, Summary Health Information and/or Limited Data Sets.

b. **Protected Health Information Disclosure**
Business Associate may disclose, in conformance with the HIPAA Privacy Regulation, Individuals' Protected Health Information to make Incidental Disclosures and to make disclosures of Deidentified Information, Limited Data Set Information, and Summary Health Information.

4. **Minimum Necessary and Limited Data Set.**
Business Associate's use, disclosure or request of Protected Health Information shall utilize a Limited Data Set if practicable. Otherwise, Business Associate will make reasonable efforts to use, disclose, or request only the minimum necessary amount of Individuals' Protected Health Information to accomplish the intended purpose.

D. Disclosure to Plan and Employer (and their Subcontractors)
Other than disclosures permitted by Section I.C above, Business Associate will not disclose Individuals' Protected Health Information to the Plan, its Plan administrator or Employer, or any business associate or subcontractor of such parties except as set forth in Section VIII.

E. Disclosure to Business Associate's Subcontractors and Agents
Business Associate will require its subcontractors and agents to provide reasonable assurance, evidenced by written contract, that such other entity will comply with the same privacy and security obligations with respect to Individuals' Protected Health Information as applies to Business Associate.

F. Reporting Non-Permitted Use or Disclosure, Breaches and Security Incidents

1. Non-permitted Use or Disclosure. Business Associate will promptly report to the Plan any use or disclosure of Individuals' Protected Health Information not permitted by this Agreement or in writing by the Plan or its Plan administrator, of which Business Associate becomes aware. Such report shall not include instances where Business Associate inadvertently misroutes Protected Health Information to a provider.

2. Security Incidents. In addition to reporting to Plan any use or disclosure of Protected Health Information not permitted by the Agreement, Business Associate will also report any Breach or security incidents of which Business Associate becomes aware. A security incident is an attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system, and involves only electronic Protected Health Information that is created, received maintained or transmitted by or on behalf of Business Associate, that is in electronic form. The parties acknowledge and agree that this section constitutes notice by Business Associate to Company of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to Company shall be required. "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI or NPFI.

3. Breach. Business Associate will promptly report to Plan any Breach of Unsecured PHI. Business Associate will cooperate with Plan in investigating the Breach and in meeting the Plan's obligations under the HITECH Act and other applicable Security Breach notification laws. In addition to providing notice to Plan of a Breach, Business Associate will provide any required notice to individuals and applicable regulators on behalf of Plan, unless Plan is otherwise notified by Business Associate

G. Termination for Breach of Privacy Obligations

Without limiting the rights of the parties set forth in the ASO agreement, each party will have the right to terminate this Agreement and the ASO Agreement if the other has engaged in a pattern of activity or practice that constitutes a material breach or violation of their obligations regarding Protected Health Information under this Agreement.

Prior to terminating this Agreement as set forth above, the terminating party shall provide the other with an opportunity to cure the material breach. If these efforts to cure the material breach are unsuccessful, as determined by the terminating party in its reasonable discretion, parties shall terminate the ASO Agreement and this Agreement, as soon as administratively feasible. If for any reason a party has determined the other has breached the terms of this Agreement and such breach has not been cured, but the non-breaching party determines that termination of the Agreement is not feasible, the party may report such breach to the U.S. Department of Health and Human Services.

H. Disposition of Protected Health Information

1. Return or Destruction Upon ASO Agreement End

The parties agree that upon cancellation, termination, expiration or other conclusion of the ASO Agreement, destruction or return of all Protected Health Information, in whatever form or medium (including in any electronic medium under Business Associate's custody or control) is not feasible given the regulatory requirements to maintain and produce such information for extended periods

of time after such termination. In addition, Business Associate is required to maintain such records to support its contractual obligations with its vendors and network providers. Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those consistent with applicable law for so long as Business Associate, or its subcontractors or agents, maintains such Protected Health Information. Business Associate may destroy such records in accordance with applicable law and its record retention policy that it applies to similar records.

2. Exception When Business Associate Becomes Plan's Health Insurance Issuer

If upon cancellation, termination, expiration or other conclusion of the ASO Agreement, Business Associate (or an affiliate of Business Associate) becomes the Plan's health insurance underwriter, then Business Associate shall transfer any Protected Health Information that Business Associate created or received for or from Plan to that part of Business Associate (or affiliate of Business Associate) responsible for health insurance functions.

3. Survival of Termination

The provisions of this Section I.H. shall survive cancellation, termination, expiration, or other conclusion of this Agreement and the ASO Agreement.

II. ACCESS, AMENDMENT AND DISCLOSURE ACCOUNTING

A. Access

1. Business Associate will respond to an Individual's request for access to his or her Protected Health Information as part of Business Associate's normal customer service function, if the request is communicated to Business Associate directly by the Individual. Despite the fact that the request is not made to the Plan, Business Associate will respond to the request with respect to the Protected Health Information Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.

2. In addition, Business Associate will assist the Plan in responding to requests by Individuals that are made to the Plan to invoke a right of access under the HIPAA Privacy Regulation by performing the following functions:

   Upon receipt of written notice (includes faxed and emailed notice) from the Plan, Business Associate will make available for inspection and obtaining copies by the Plan, or at the Plan's direction by the Individual (or the Individual's personal representative), any Protected Health Information about the Individual created or received for or from the Plan in Business Associate's custody or control, so that the Plan may meet its access obligations under 45 Code of Federal Regulations § 164.524, and, where applicable, the HITECH Act. Business Associate will make such information available in an electronic format where required by the HITECH Act..

B. Amendment

1. Business Associate will respond to an Individual's request to amend his or her Protected Health Information as part of Business Associate's normal customer service functions, if the request is communicated to Business Associate directly by the Individual. Despite the fact that the request is not made to the Plan, Business Associate will respond to the request with respect to the Protected Health Information Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.

2. In addition, Business Associate will assist the Plan in responding to requests by Individuals that are made to the Plan to invoke a right to amend under the HIPAA Privacy Regulation by performing the following functions:

Upon receipt of written notice (includes faxed and emailed notice) from the Plan, Business Associate will amend any portion of the Protected Health Information created or received for or from the Plan in Business Associate's custody or control, so that the Plan may meet its amendment obligations under 45 Code of Federal Regulations §164.526.

C. **Disclosure Accounting**

1. Business Associate will respond to an Individual's request for an accounting of disclosures of his or her Protected Health Information as part of Business Associate's normal customer service function, if the request is communicated to the Business Associate directly by the Individual. Despite the fact that the request is not made to the Plan, Business Associate will respond to the request with respect to the Protected Health Information Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.

2. In addition, Business Associate will assist the Plan in responding to requests by Individuals that are made to the Plan to invoke a right to an accounting of disclosures under the HIPAA Privacy Regulation by performing the following functions so that the Plan may meet its disclosure accounting obligation under 45 Code of Federal Regulations § 164.528:

a. Disclosure Tracking

Business Associate will record each disclosure that Business Associate makes of Individuals' Protected Health Information, which is not excepted from disclosure accounting under Section II.C.2.b.

The information about each disclosure that Business Associate must record ("Disclosure Information") is (a) the disclosure date, (b) the name and (if known) address of the person or entity to whom Business Associate made the disclosure, (c) a brief description of the Protected Health Information disclosed, and (d) a brief statement of the purpose of the disclosure or a copy of any written request for disclosure under 45 Code of Federal Regulations §164.502(a)(2)(ii) or §164.512. Disclosure Information also includes any information required to be provided by the HITECH Act.

For repetitive disclosures of Individuals' Protected Health Information that Business Associate makes for a single purpose to the same person or entity (including to the Plan or Employer), Business Associate may record (a) the Disclosure Information for the first of these repetitive disclosures, (b) the frequency, periodicity or number of these repetitive disclosures, and (c) the date of the last of these repetitive disclosures.

b. Exceptions from Disclosure Tracking

Business Associate will not be required to record Disclosure Information or otherwise account for disclosures of Individuals' Protected Health Information (a) for Treatment, Payment or Health Care Operations, (except where required by the HITECH Act, as of the effective dates of such requirements) (b) to the Individual who is the subject of the Protected Health Information, to that Individual's personal representative, or to another person or entity authorized by the Individual (c) to persons involved in that Individual's health care or payment for health care as provided by 45 Code of Federal Regulations § 164.510, (d) for notification for disaster relief purposes as provided by 45 Code of Federal Regulations § 164.510, (e) for national security or intelligence purposes, (f) to law enforcement officials or correctional institutions regarding inmates, (g) that are

incident to a use or disclosure that is permitted by this Agreement or the ASO Agreement, (h) as part of a limited data set in accordance with 45 Code of Federal Regulations § 164.514(e), or (i) that occurred prior to the Plan's compliance date.

c. Disclosure Tracking Time Periods

Unless otherwise provided by the HITECH Act and/or any accompanying regulations, Business Associate will have available for the Plan the Disclosure Information required by Section II.C.2.a above for the six (6) years immediately preceding the date of the Plan's request for the Disclosure Information.

d. Provision of Disclosure Accounting

Upon receipt of written notice (includes faxed and emailed notice) from the Plan, Business Associate will make available to the Plan, or at the Plan's direction to the Individual (or the Individual's personal representative), the Disclosure Information regarding the Individual, so the Plan may meet its disclosure accounting obligations under 45 Code of Federal Regulations § 164.528 and the HITECH Act.

D. Confidential Communications

1. Business Associate will respond to an Individual's request for a confidential communication as part of Business Associate's normal customer service function, if the request is communicated to Business Associate directly by the Individual. Despite the fact that the request is not made to the Plan, Business Associate will respond to the request with respect to the Protected Health Information Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation. If an Individual's request, made to Business Associate, extends beyond information held by Business Associate or Business Associate's subcontractors, Business Associate will inform the Individual to direct the request to the Plan, so that Plan may coordinate the request. Business Associate assumes no obligation to coordinate any request for a confidential communication of Protected Health Information maintained by other business associates of Plan.

2. In addition, Business Associate will assist the Plan in responding to requests by Individuals that are made to the Plan to invoke a right of confidential communication under the HIPAA Privacy Regulation by performing the following functions:

   Upon receipt of written notice (includes faxed and emailed notice) from the Plan, Business Associate will begin to send all communications of Protected Health Information directed to the Individual to the identified alternate address so that the Plan may meet its access obligations under 45 Code of Federal Regulations § 164.524.

E. Restrictions

1. Business Associate will respond to an Individual's request for a restriction as part of Business Associate's normal customer service function, if the request is communicated to Business Associate directly by the Individual. Despite the fact that the request is not made to the Plan, Business Associate will respond to the request with respect to the Protected Health Information Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.

2. In addition, Business Associate will promptly, upon receipt of notice from Plan, restrict the use or disclosure of Individuals' Protected Health Information, provided the Business Associate has agreed to such a restriction. Plan and Employer understand that Business

Associate administers a variety of different complex health benefit arrangements, both insured and self-insured, and that Business Associate has limited capacity to agree to special privacy restrictions requested by Individuals. Accordingly, Plan and Employer agree that it will not commit Business Associate to any restriction on the use or disclosure of Individuals' Protected Health Information for Treatment, Payment or Health Care Operations without Business Associate's prior written approval.

III. SAFEGUARD OF PROTECTED HEALTH INFORMATION

Business Associate will develop and maintain reasonable and appropriate administrative, technical and physical safeguards, as required by Social Security Act § 1173(d) and 45 Code of Federal Regulations §164.530(a) and (c) and as required by the HITECH Act, to ensure and to protect against reasonably anticipated threats or hazards to the security or integrity of health information, to protect against reasonably anticipated unauthorized use or disclosure of health information, and to reasonably safeguard Protected Health Information from any intentional or unintentional use or disclosure in violation of this Agreement.

Business Associate will also develop and use appropriate administrative, physical and technical safeguards to preserve the Availability of electronic Protected Health Information, in addition to preserving the integrity and confidentiality of such Protected Health Information. The "appropriate safeguards" Business Associate uses in furtherance of 45 Code of Federal Regulations §164.530(c), will also meet the requirements contemplated by 45 Code of Federal Regulations Parts 160, 162 and 164, as amended from time to time.

IV. COMPLIANCE WITH STANDARD TRANSACTIONS

Business Associate will comply with each applicable requirement for Standard Transactions established in 45 Code of Federal Regulations Part 162 when conducting all or any part of a Standard Transaction electronically for, on behalf of, or with the Plan.

V. INSPECTION OF BOOKS AND RECORDS

Business Associate will make its internal practices, books, and records relating to its use and disclosure of Protected Health Information created or received for or from the Plan available to the U.S. Department of Health and Human Services to determine Plan's compliance with 45 Code of Federal Regulations Parts 160-64 or this Agreement.

VI. MITIGATION FOR NON-PERMITTED USE OR DISCLOSURE

Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

PART 2 – PLAN'S RESPONSIBILITIES

VII. PLAN'S NOTICE OF PRIVACY PRACTICES

A. Preparation of Plan's Notice of Privacy Practices. Plan shall be responsible for the preparation of its Notice of Privacy Practices ("NPP"). To facilitate this preparation, upon Plan's or Employer's request, Business Associate will provide Plan with its NPP that Plan may use as the basis for its own NPP. Plan will be solely responsible for the review and approval of the content of its NPP, including whether its content accurately reflects Plan's privacy policies and practices, as well as its compliance with the requirements of 45 C.F.R. § 164.520. Unless advance written approval is obtained from Business Associate, the Plan shall not create any NPP that imposes obligations on Business Associate that are in addition to or that are inconsistent with the NPP prepared by Business Associate or with the obligations assumed by Business Associate hereunder.

B. Distribution of Notice of Privacy Practice. Plan shall bear full responsibility for distributing its own NPP as required by the Privacy Regulation.

C. **Changes to Protected Health Information.** Plan shall notify Business Associate of any change(s) in, or revocation of, permission by an Individual to Use or Disclose Protected Health Information, to the extent that such change(s) may affect Business Associate's Use or Disclosure of such Protected Health Information.

PART 3—DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE PLAN, EMPLOYER AND OTHER BUSINESS ASSOCIATES

VIII. DISCLOSURE OF PROTECTED HEALTH INFORMATION

The following provisions apply to disclosures of Protected Health Information to the Plan, Employer and other business associates of the Plan.

A. Disclosure to Plan

Unless otherwise provided by this Section VIII, all communications of Protected Health Information by Business Associate shall be directed to the Plan.

B. Disclosure to Employer

Business Associate may provide Summary Health Information regarding the Individuals in the Plan to Employer upon Employer's written request for the purpose either (a) to obtain premium bids for providing health insurance coverage for the Plan, or (b) to modify, amend or terminate the Plan.

Business Associate may provide information to Employer on whether an individual is participating in the Plan or is enrolled in or has disenrolled from any insurance coverage offered by the Plan.

C. Disclosure to Other Business Associates and Subcontractors

Business Associate may disclose Individuals' Protected Health Information to other entities or business associates of the Plan if the Plan authorizes Business Associate in writing to disclose Individuals' Protected Health Information to such entity or business associate. The Plan shall be solely responsible for ensuring that any contractual relationships with these entities or business associates and subcontractors comply with the requirements of 45 Code of Federal Regulations § 164.504(e) and § 164.504(f).

PART 4—MISCELLANEOUS

IX. AGREEMENT TERM

This Agreement will continue in full force and effect for as long as the ASO Agreement remains in full force and effect. This Agreement will terminate upon the cancellation, termination, expiration or other conclusion of the ASO Agreement.

X. AUTOMATIC AMENDMENT TO CONFORM TO APPLICABLE LAW

Upon the effective date of any final regulation or amendment to final regulations with respect to Protected Health Information, Standard Transactions, the security of health information or other aspects of the Health Insurance Portability and Accountability Act of 1996 applicable to this Agreement or to the ASO Agreement, this Agreement will automatically amend such that the obligations imposed on the Plan, Employer, and Business Associate remain in compliance with such regulations, unless Business Associate elects to terminate the ASO Agreement by providing Employer notice of termination in accordance with the ASO Agreement at least thirty (30) days before the effective date of such final regulation or amendment to final regulations.

XI. CONFLICTS

The provisions of this Agreement will override and control any conflicting provision of the ASO Agreement. All other provisions of the ASO Agreement remain unchanged by this Agreement and in full force and effect.

XII. NO THIRD PARTY BENEFICIARIES

The parties agree that there are no intended third party beneficiaries under this Agreement. This provision shall survive cancellation, termination, expiration, or other conclusion of this Agreement and the ASO Agreement.

XIII. INTERPRETATION

Any ambiguity in this Agreement or the ASO Agreement or in operation of the Plan shall be resolved to maintain compliance with the Regulations enacted pursuant to HIPAA Administrative Simplification.

XIV. DEFINITIONS

Unless otherwise defined in this Agreement, the capitalized terms set forth herein have the meanings ascribed to them under the HIPAA Privacy Regulation and/or HIPAA Security Regulation or the HITECH Act. A reference in this Agreement to the Privacy Regulation, Security Regulation or HIPAA shall mean the section as in effect or as amended,

XV. REFERENCES

References herein to statutes and regulations shall be deemed to be references to those statutes and regulations as amended or recodified.

On Behalf of the Group Health Plan and Employer:	**Business Associate:**
City of Greenwood	
Name of the Group Health Plan/Employer	*Name of Business Associate*
Signature	*Signature*
Mark Myers	
Printed Name	*Printed Name*
Mayor	
Title	*Title*
Date	*Date*

Protected Health Information Report Request Form — ASO

Anthem BlueCross BlueShield

INSTRUCTIONS:

Group Health Plan Representative: Please complete this form and return it to your Anthem Sales Representative.

☐ **Check here if a single report is needed.** Complete Sections 1 through 6 on page 1.

☐ **Check here if multiple reports are needed.** Complete Section 1 and provide signatures in Section 6. Then go to page 2 to complete information in Section 7.

SECTION 1: GROUP HEALTH PLAN INFORMATION

Provide full legal name (e.g., use official corporate name such as "XYZ Company, Inc.").

Group's full name	Group's health plan no.
City of Greenwood	

Approved Benefit Office Representative (Group Representative name)

Group's address (street and P.O., if applicable)	City	State	ZIP code	County
300 S Madison Ave	Greenwood	IN	46143	Johnson

SECTION 2: THIRD-PARTY INFORMATION

If the Group wants a business associate or other third party to receive a copy of the Report, fill in the following information.

Name of third party	Reason for disclosure of report
Regions Insurance	
Third-party's full mailing address or email address pierre.fox@regions.com	Relationship of third-party ☐ New carrier ☑ Broker ☐ Vendor ☐ Other_____

Note that if Anthem's proprietary information is included in any report shared with a group's vendor or other third party, a Confidentiality Agreement will be required.

SECTION 3: FREQUENCY OF REPORT

☐ One time only ☑ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually ☐ Other: _____

Note that this request is valid for the Group's renewal period. At the end of that period, a new Request Form must be submitted.

SECTION 4: INFORMATION BEING REQUESTED

Could this request be fulfilled using Summary Health Information or de-identified information? ☐ Yes ☐ No
If not, please explain.

Standard report(s) or extracts requested:	Non-standard report(s) or extracts requested: specifically list the data elements requested:

SECTION 5: REASON BEING REQUESTED

☐ Audit ☐ Enrollment ☐ Billing ☐ Financial analysis ☐ Stop-loss/Reinsurance
☑ Benefit analysis ☐ Other (state reason for request): _____

☐ Clinical analysis. If clinical and/or provider analysis, please identify the use(s) of the PHI requested:

☐ Provider access
☐ Morbidity distribution of members
☐ EAP activity opportunities
☐ Identify high volume providers
☑ Monitor catastrophic cases
☑ Predictive modeling
☐ Repricing
☑ Stop loss/reinsurance
☐ Transition of Care
☐ Transition to a new carrier
☐ Disease management & wellness program opportunities
☐ Other (state reason for request): _____
☑ UM Management
☐ Wellness incentives

SECTION 6: REQUIRED SIGNATURES

Upon receipt of this Request Form, Anthem will review the request. By signing below, the Group Health Plan agrees: (1) that the Group and its agents will comply with applicable HIPAA Privacy Regulations, including the minimum necessary requirements; and (2) that the Group, and its agents will keep any Anthem proprietary information confidential and will not further use or disclose this information without Anthem's advance written notice.

By: _____ Mayor _____

Signature | Title (Approved Benefit Office Representative) | Date

SECTION 7: MULTIPLE REPORTS ONLY

REPORT 1

THIRD-PARTY INFORMATION

Name of third party	Reason for disclosure of report
Third-party's full mailing address or email address	Relationship of third-party ☐ New carrier ☐ Broker ☐ Vendor ☐ Other_____

FREQUENCY OF REPORT*

☐ One time only ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually ☐ Other: _____

INFORMATION BEING REQUESTED

Could this request be fulfilled using Summary Health Information or de-identified information? ☐ Yes ☐ No
If not, please explain.

☐ Standard report(s) or extracts	☐ Non-standard report(s) or extracts: specifically list the data elements requested:

REASON BEING REQUESTED

☐ Audit ☐ Enrollment ☐ Billing ☐ Financial analysis ☐ Stop-loss/Reinsurance
☐ Benefit analysis ☐ Other (state reason for request): _____

☐ Clinical analysis. If clinical and/or provider analysis, please identify the use(s) of the PHI requested:

- ☐ Provider access
- ☐ Morbidity distribution of members
- ☐ EAP activity opportunities
- ☐ Identify high volume providers
- ☐ Monitor catastrophic cases
- ☐ Predictive modeling
- ☐ Repricing
- ☐ Stop loss/reinsurance
- ☐ Transition of Care
- ☐ Transition to a new carrier
- ☐ Disease management & wellness program opportunities
- ☐ Other (state reason for request): _____
- ☐ UM Management
- ☐ Wellness incentives

REPORT 2

THIRD-PARTY INFORMATION

Name of third party	Reason for disclosure of report
Third-party's full mailing address or email address	Relationship of third-party ☐ New carrier ☐ Broker ☐ Vendor ☐ Other_____

FREQUENCY OF REPORT*

☐ One time only ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually ☐ Other: _____

INFORMATION BEING REQUESTED

Could this request be fulfilled using Summary Health Information or de-identified information? ☐ Yes ☐ No
If not, please explain.

☐ Standard report(s) or extracts	☐ Non-standard report(s) or extracts: specifically list the data elements requested:

REASON BEING REQUESTED

☐ Audit ☐ Enrollment ☐ Billing ☐ Financial analysis ☐ Stop-loss/Reinsurance
☐ Benefit analysis ☐ Other (state reason for request): _____

☐ Clinical analysis. If clinical and/or provider analysis, please identify the use(s) of the PHI requested:

- ☐ Provider access
- ☐ Morbidity distribution of members
- ☐ EAP activity opportunities
- ☐ Identify high volume providers
- ☐ Monitor catastrophic cases
- ☐ Predictive modeling
- ☐ Repricing
- ☐ Stop loss/reinsurance
- ☐ Transition of Care
- ☐ Transition to a new carrier
- ☐ Disease management & wellness program opportunities
- ☐ Other (state reason for request): _____
- ☐ UM Management
- ☐ Wellness incentives

*Note that the request is valid for the Group's renewal period. At the end of this period, a new Request Form must be submitted.

SECTION 7: MULTIPLE REPORTS ONLY *CONTINUED*

REPORT 3

THIRD-PARTY INFORMATION

Name of third party	Reason for disclosure of report
Third-party's full mailing address or email address	Relationship of third-party ☐ New carrier ☐ Broker ☐ Vendor ☐ Other_____

FREQUENCY OF REPORT*

☐ One time only ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually ☐ Other: _____

INFORMATION BEING REQUESTED

Could this request be fulfilled using Summary Health Information or de-identified information? ☐ Yes ☐ No
If not, please explain.

☐ Standard report(s) or extracts	☐ Non-standard report(s) or extracts: specifically list the data elements requested:

REASON BEING REQUESTED

☐ Audit ☐ Enrollment ☐ Billing ☐ Financial analysis ☐ Stop-loss/Reinsurance
☐ Benefit analysis ☐ Other (state reason for request): _____

☐ Clinical analysis. If clinical and/or provider analysis, please identify the use(s) of the PHI requested:

☐ Provider access
☐ Morbidity distribution of members
☐ EAP activity opportunities
☐ Identify high volume providers
☐ Monitor catastrophic cases
☐ Predictive modeling
☐ Repricing
☐ Stop loss/reinsurance
☐ Transition of Care
☐ Transition to a new carrier
☐ Disease management & wellness program opportunities
☐ Other (state reason for request): _____
☐ UM Management
☐ Wellness incentives

REPORT 4

THIRD-PARTY INFORMATION

Name of third party	Reason for disclosure of report
Third-party's full mailing address or email address	Relationship of third-party ☐ New carrier ☐ Broker ☐ Vendor ☐ Other_____

FREQUENCY OF REPORT*

☐ One time only ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually ☐ Other: _____

INFORMATION BEING REQUESTED

Could this request be fulfilled using Summary Health Information or de-identified information? ☐ Yes ☐ No
If not, please explain.

☐ Standard report(s) or extracts	☐ Non-standard report(s) or extracts: specifically list the data elements requested:

REASON BEING REQUESTED

☐ Audit ☐ Enrollment ☐ Billing ☐ Financial analysis ☐ Stop-loss/Reinsurance
☐ Benefit analysis ☐ Other (state reason for request): _____

☐ Clinical analysis. If clinical and/or provider analysis, please identify the use(s) of the PHI requested:

☐ Provider access
☐ Morbidity distribution of members
☐ EAP activity opportunities
☐ Identify high volume providers
☐ Monitor catastrophic cases
☐ Predictive modeling
☐ Repricing
☐ Stop loss/reinsurance
☐ Transition of Care
☐ Transition to a new carrier
☐ Disease management & wellness program opportunities
☐ Other (state reason for request): _____
☐ UM Management
☐ Wellness incentives

*Note that the request is valid for the Group's renewal period. At the end of this period, a new Request Form must be submitted.

Actively-at-work Disclosure Statement
Anthem Life

Anthem Life

In column one below enter a "1" or "2" according to the following.

1 – The proposed insurance contract contains a provision excluding coverage for employees who are not actively at work other than for reasons of disability. This means an employee is not present to carry out normal assigned duties. As an underwriting consideration, the provision MAY be waived for such persons if the employer discloses the following pertinent details regarding all such known individuals as of a date not exceeding 35 days prior to the proposed effective date. Please use a (1) to denote these individuals.

2 – This provision does **not** apply to persons not actively at work for reasons of disability, but we ask that they be listed below also if they are otherwise eligible for coverage and the employer wishes to have them covered on the effective date. Please use a (2) to denote these persons.

SECTION 1: EMPLOYEE INFORMATION

1 or 2 see above	Employee name	Employee or Dependent	Sex	Birthdate	Date leave began	(1) Reason for leave (2) Diagnosis/nature of disability	Current status	Expected return date	Benefits paid in last 12 months
☐1 ☐2	Jeff McCorkle	☒ Employee ☐ Dependent	☒ M ☐ F			Mental Health	On leave (Short Term)	Undetermined	
☐1 ☐2		☐ Employee ☐ Dependent	☐ M ☐ F						
☐1 ☐2		☐ Employee ☐ Dependent	☐ M ☐ F						
☐1 ☐2		☐ Employee ☐ Dependent	☐ M ☐ F						
☐1 ☐2		☐ Employee ☐ Dependent	☐ M ☐ F						
☐1 ☐2		☐ Employee ☐ Dependent	☐ M ☐ F						
☐1 ☐2		☐ Employee ☐ Dependent	☐ M ☐ F						
☐1 ☐2		☐ Employee ☐ Dependent	☐ M ☐ F						
☐1 ☐2		☐ Employee ☐ Dependent	☐ M ☐ F						
☐1 ☐2		☐ Employee ☐ Dependent	☐ M ☐ F						

SECTION 2: SIGNATURE – Required

The employer named below, through its authorized officer, hereby represents that the above list is true, complete and accurate to the best of his/her knowledge and belief, and that nothing has been knowingly or intentionally omitted. The employer further acknowledges, understands and agrees that this information will be used to evaluate the pricing of the proposed coverage and that no coverage will be provided for non-disabled individuals unless specifically agreed to by the insurer. Please note if it is requested that actively at work provisions be waived for non-disabled individuals

Employer name	Authorized officer signature	Authorized officer name	Title	Date
City of Greenwood	X [signature]	Mark Myers	Mayor	

Anthem Electronic Funds Transfer (EFT) Authorization Form – Indiana

Anthem BlueCross BlueShield

We authorize Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), to initiate debit entries of premiums or any other related payments on our behalf and credit entries as required to our account indicated below, and authorize the financial institution named below to debit/credit the same to such account.

Enrollment type	Requested effective date
☑ New ☐ Revised	04/01/2016

SECTION 1: FINANCIAL INSTITUTION INFORMATION

Financial institution name			
Regions Bank			
Street address	**City**	**State**	**ZIP code**
1 Indiana Square	Indianapolis	IN	46204
Account no.	**Bank ABA no.**		
0163807491	074014213		

Account type
☒ Checking/NOW ☐ Savings ☐ Other: _____

PLEASE ATTACH A VOIDED CHECK.

SECTION 2: GROUP INFORMATION

Group name		Anthem group no.	
City of Greenwood			
Street address	**City**	**State**	**ZIP code**
300 S Madison Ave	Greenwood	IN	46142
Contact person	**Phone no.**	**Email address**	
Kathie Fritz	317-887-5604	fritzk@greenwood.in.gov	

SECTION 3: SIGNATURE – Required

This authorization is to remain in full force and effect until Anthem and the above-named financial institution have received written notification simultaneously from us of its termination in such time and in such manner as to afford Anthem and the above-named financial institution a reasonable opportunity to act on it.

Authorized signature on account	Name	Title	Date
X Kathie Fritz	Kathie Fritz	Deputy Controller	02232016

FOR ANTHEM USE ONLY

Anthem authorized signature	Name	Title	Date
X			

Send completed form to:
Anthem Blue Cross and Blue Shield
PO Box 37160
Louisville, KY 40233-7160

Self-Funded Rating Proposal

Anthem

City of Greenwood

Effective Date: 04/01/2016

Discount Plan: Full Discount

		8.0 CSOS (PPO)
		Total Number of Contracts
		Composite
		223
FIXED COSTS		
Administrative Fees:		Composite
Administrative Fee	Medical/Rx *	$49.90
	360 Health	$2.42
Stop-Loss Premium:		
Aggregate @	% of expected claims	125%
Aggregate Rate		$9.16
Specific @	Per Member	$125,000
Aggregating Specific @		$25,000
Specific Rate		$100.20
Total Costs		**$161.68**
CLAIMS EXPENSE		
		Composite
Expected Claims Liability:		$1,285.74
Maximum Claims Liability:		$1,607.18
TOTAL COST		
At Expected:		Annualized
Fixed Cost		$468,713.83
Expected Claims Expense		$3,727,360.26
Total Costs		$4,196,074.09
At Maximum:		
Fixed Cost		$468,713.83
Maximum Claims Expense		$4,659,214.82
Total Costs		$5,127,928.65
Minimum Aggregate Attachment Amount:		$4,426,254.08
COVERED NETWORK BENEFITS		
Covered Benefits		BENEFIT PLAN
Physician Office Services		$20 / $35
IP Facility		20% : 30%
OP Surgery/Hosp/ACF Facility		20% : 30%
Other OP Facility		20% : 30%
Deductible (single/family)		$500/$1,000 : $1,000/$2,000
Out-of-Pocket Maximum (single/family)	$2000/$4000	~~$1,500/$3,000~~ : $5,000/$10,000
Lifetime Maximum		Unlimited
Rx - Network Pharmacy		~~$5~~/$25/$40/$60: $10/$50/$80/$120
Rx - Deductible	$10	

ASSUMPTIONS

Refer to Attached Assumptions/Conditions page.
BlueCard charges will apply to claims incurred outside of Anthem Midwest States.
Our Administrative Fee incorporates a reduction in consideration of your placing your Rx program with us. Should you choose, and be approved by Anthem, to place your Rx program elsewhere your Administrative Fee will be adjusted.
*The following AIM benefits are included in Admin: Integrated Imaging, Sleep Medicine & Oncology.
The 360° Health Programs quoted are:
- ComplexCare
- Future Moms Maternity Program (with Proactive ID Mailings)
- 24/7 Nurseline
- ConditionCare - 5 Core Chronic Diseases (diabetes, asthma, heart failure, CAD, COPD, ESRD)

Full 360 charges are $3.23 pepm, due to implementation delay of 90 days from group effective date, Anthem is charging 9/12ths of the full price. Upon renewal, full 360 charges will be billed each month. The price illustrated in this exhibit is the 9/12ths price.
HOTT covered same as any other condition subject to Specific

Contract Terms for Stop Loss:	18/12
Liability Limit:	
Specific Stop Loss Maximum:	Unlimited
Aggregate Stop Loss Maximum:	Unlimited
Broker Commissions on Stop Loss Premium:	NET
Specific Stop Loss Lines of Coverage:	Medical+Rx
Aggregate Stop Loss Lines of Coverage:	Medical+Rx
Estimate Member Conversion Factor:	2.8

This proposal provides Anthem's best estimate of expected claims costs at the issue date. Numbers will vary from actual claims experienced.

Anthem Issue Date: 02/17/2016

(ver 7.23.14)

Signature: Mayor

Date: 02/19/2016

Title: Mayor

City of Greenwood
Effective Date: 04/01/2016

Assumptions and Conditions:

The services, rates and fees within this proposal assume an effective date of 04/01/2016

Anthem reserves the right to revise this proposal under any of the following circumstances:

(1) a change to the Plan benefits initiated by Employer that results in a substantial change in the services to be provided by Anthem.

(2) a change in ownership

(3) a change in the total number of Members resulting in either an increase or decrease of 10% or more of the of the number of Members used to calculate the rates

(4) a change in Employer contribution

(5) a change in nature of Employer's business resulting in a change in its designated Standard Industrial Classification ("SIC") code; or

(6) a change in applicable law that results in an increase in the cost or amount of administrative services from those currently being provided by Anthem. The cost for our standard reporting package is included in the proposed ASO fee. Non-standard reports may be subject to additional fee depending on the complexity and frequency requested.

Electronic eligibility or tape feeds must be in a format compatible with our systems.

Anthem requires that City of Greenwood contributes a minimum of 50% of the employee premium for all active and retired employees enrolled in the group health plan and 25% of overall premium.

Anthem requires that 75% of City of Greenwood'(s) net eligible employees and 50% of the total eligible employees enroll in the group sponsored health care program. If City of Greenwood contributes 100% of the employee cost, Anthem requires that 100% of City of Greenwood'(s) net eligible employees and 50% of the total eligible employees enroll in the group sponsored health care program.

An eligible employee is defined as an active, permanent employee who works for pay or profit at least 30 hours per week, 50 weeks per year as of the effective date and who completes the group imposed waiting period.

We will rely on the information provided to determine whether a proposal will be issued. The information provided shall become a part of the application for stop loss coverage. You are obligated to provide accurate information. If material errors or omissions are found after the quote is issued, we reserve the right to revise the quote in any manner or rescind the quote even if you were unaware of the material error or omission. Additionally, we reserve the right to rescind the proposal in its entirety based on our review of all the information submitted during the proposal process.

Offer is ASO with Anthem Stop Loss.

This proposal assumes that Anthem will be the only carrier offered.

Claims will be paid based on Anthem's medical policy. If claims are determined by outside stop loss carrier to be not in accordance with their medical policy and therefore not covered under stop loss, the group is still required to fund such claim.

Surgical Quality and Safety Management Program = $300.00 per occurrence.

This proposal is contingent upon completion and acceptance of the signed New Sale Disclosure Statement.

The benefits reflected in your proposal have been adjusted to include the Benefit Enhancements for The Patient Protection and Affordable Care Act (PPACA). Please note: As we receive additional guidance and clarification from the U. S. Department of Health and Human Services, we may be required to make additional changes to your

benefits. At this time, we do not expect rates to be impacted by these changes.

The benefits reflected in this quotation have been adjusted to comply with changes required by the Affordable Care Act beginning in 2014.

The Health benefit plan(s) reflected in this proposal is(are) not considered to be grandfathered under the provisions of the Patient Protection and Affordable Care Act. Non-grandfathered plans are subject to additional provisions under the Patient Protection and Affordable Care Act that do not apply to grandfathered plans. For further information, please contact your account representative.

Section 1341 of the Affordable Care Act (ACA or health care reform law) provides that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market during the year 2014 through 2016.
This quote or renewal does not include the ACA Reinsurance Fees, since it is assumed that the employer will remit payment to HHS directly.

Please note, at this time, we do not know if additional guidance and clarification from the U.S. Department of Health and Human Services will require additional changes to rates and benefits. For clarification purposes:

* IRS has jurisdiction over the Insurer Fee and HHS over Reinsurance Fee.
* Rates and benefits for most large groups are likely to change - further communication will be sent as soon as we have additional information

Anthem shall retain the difference, if any, between the invoiced amount to City of Greenwood and the amount paid to the pharmacy benefit manager for prescription drugs dispensed to members as a portion of Anthem's reasonable compensation for services provided to City of Greenwood.

Some clients will purchase high deductible plans from an insurance carrier, but communicate a richer plan to their employees. The pricing of high deductible plans assumes a utilization savings driven by the high deductible. If the members assume a lower deductible, the utilization savings will not emerge. Hence, the insurance carrier will not be collecting enough premium. For this reason, our offer assumes that there is no other plan in place, either through another carrier or an employer funded plan, whether funded via an HSA or another method.

Our proposal assumes the client's current arrangement and/or reports provided are not based on a Medicare Cost Plus financial arrangement. If this assumption is wrong, our offer is invalid.

This is a choice offering. At least 20% of the total enrollment must participate in each plan.

Broker Commission: NET of Stop Loss Premium

This proposal is not intended to duplicate the current plan.

ASO fees and stop loss premiums will be invoiced on the first full week of the month and due within three business days. Claims are billed weekly.

If City of Greenwood is delinquent in payment for the weekly claims billing, Anthem will not process further claims until the account is brought current.

Specific stop loss will be reviewed by Underwriting monthly, until the aggregating specific corridor has been met. Once the aggregating specific corridor has been met, Anthem will assume immediate reimbursement for the additional specific stop loss claims. A final settlement will be performed to finalize reimbursements. Those claims meeting the aggregating specific corridor will not be included when determining Aggregate Attachment.

Under this 16/12 arrangement, only those claims incurred 4 months prior to 04/01/2016 and paid within the contract period are used to determine the Specific and Aggregate Attachments.

This proposal assumes Demand Debit will be the method of payment.

This proposal assumes a 2.8 member/contract ratio. If this relationship changes by more than 10%, then Anthem holds the right to adjust this proposal.

This proposal expires 60 days from the date of release of this proposal or on 04/01/2016, whichever is sooner.

The Employer signature is required to acknowledge receipt of this proposal and Assumption Page.

Signature: _____ Title: Mayor

Date: 02/15/2024

SIC Code: 5271
Experience & Demographic Rated

City of Greenwood
Effective Date: 04/01/2016

HMO, PPO, POS

Assumptions and Conditions:

- **Customized Health Care Management Services**

☐ Customized Precertification Services
☐ Customized Case Management Services

☑ **360° Health**
- Condition Care Core Program - Asthma, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Coronary Artery Disease, Diabetes, and ESRD

- **Condition Care Options**
  - ☐ Vascular-at-risk
  - ☐ Low back pain
  - ☐ Musculoskeletal
  - ☐ Oncology
  - ☐ Chronic Kidney Disease (pre-ESRD)
  - ☐ End Stage Renal Disease

☑ **ComplexCare**

- **MyHealth Coach**
  - ☐ Standard
  - ☐ Increase Engagement (per 1%)
  - ☐ Enhanced Staffing Ratio
  - ☐ Stand-Alone (no other core ConditionCare services)
  - ☐ Dedicated Team
  - ☐ Custom Reporting

- **My Health Advantage**
  - ☐ Silver Level
  - ☐ Gold Level
  - ☐ Gold Level without Daily Alerts
  - ☐ Platinum Level

☑ **Future Moms Maternity Program**

☑ **24/7 NurseLine**

- **Better Health** (web-based wellness programs: exercise, nutrition, weight, smoking, sleep, stress)
  - ☐ Better Health
  - ☐ Better Health + Better Health HRA

- **Healthy Lifestyles**
  - ☐ Online (Web-based programs only)
  - ☐ One-on-One Coaching (Online+Tobacco Cessation, Weight Management, Diet, Exercise, Stress Coaching)
  - ☐ One-on-One Gym network (+Online)
  - ☐ Complete (Online, Coaching and Gym Network)
  - ☐ Smoking Cessation Coaching (+Online)
    - ☐ With Nicotine Replacement Therapy
    - ☐ Without Nicotine Replacement Therapy
  - ☐ Lifestyles Direct (Tobacco Cessation, Weight Management, Diet, Exercise, Stress Coaching only)

- **Worksite Wellness** (Service fees may apply to any changes or cancellations to service orders with less than 15 calendar days' notice prior to the event date)
  - ☐ Well Advisor
    - ☐ Face-to-Face (per Advisor)
    - ☐ Learning Center (per Advisor)

- ☐ Health Seminars
  - ☐ On-site delivery
  - ☐ Tele-web Cast
- ☐ Health Risk Assessments
  - ☐ Mail-based delivery option
  - ☐ Onsite delivery option
- ☐ Seasonal Influenza Vaccinations
- ☐ Stress Management through Therapeutic Massage
- ☐ Health Screenings with Aggregate Summary Reporting
  - ☐ Weight Management Screening - BMI, Body Fat and Hip to Waist Ratio
  - ☐ Blood Pressure Screening
  - ☐ Total Cholesterol & High Density Lipids (TC/HDL)
  - ☐ Total Cholesterol & Glucose
  - ☐ BMI - Body Mass Index
  - ☐ Body Fat Screening
  - ☐ Know Your Numbers (TC/HDL, blood pressure, BMI)
  - ☐ Know your Numbers Plus (TC/HDL, blood pressure, BMI, Glucose)
  - ☐ Lipid Panel
  - ☐ Lipid Panel with Blood Pressure and BMI
  - ☐ Lipid Panel with Blood Pressure, BMI and Glucose
  - ☐ Alternative Means Screenings - Physician Fax-Back Form
- ☐ Wellness Challenge
  - ☐ Fitness Challenge
  - ☐ Weight Challenge

- **Staying Healthy Reminders**
  - ☐ Basic
    - ☐ IVR Campaign
  - ☐ Deluxe
    - ☐ IVR Campaign
  - ☐ Premium
    - ☐ IVR Campaign

- **National Imaging Management Program** for Local ASO
  - ☐ Standard Radiology Utilization and Quality Management Program, includes Patient Safety Initiative and Web Awareness Campaign
  - ☐ Standard Radiology Educational Only Program, includes Patient Safety Initiative and Web Awareness Campaign
  - ☐ OptiNet Cost / Capability Transparency Tool (As of 01/01/2011 - available in all Anthem markets except VA)
  - ☐ Cardiac Services Program (Transthoracic Echocardiography, Stress Echocardiography, Transesophageal Echocardiography)(As of 01/01/2011 - available in all Anthem markets except VA)

☐ **Anthem Health Rewards Incentive Programs - Gift Cards**

☐ **Anthem Health Rewards Incentive Programs**
- ☐ Direct Incentives
  - ☐ Health Assessment Completion
  - ☐ Condition Care Core Program
  - ☐ Future Moms Maternity Program
  - ☐ Special Campaign
- ☐ Direct Incentives
  - ☐ Health Assessment Completion
  - ☐ Condition Care Core Program
  - ☐ Future Moms Maternity Program
  - ☐ Special Campaign
  - ☐ Better Health

☐ Self-Reported Activities

Signature: Mark W Mayo Title: Mayor

Date: 02/18/2016

SIC Code: 5271
Experience & Demographic Rated

Thank you for choosing PrimePay's COBRA Solution! We know you have other options for COBRA administration, and we thank you for your continued trust and partnership. To begin your COBRA renewal, please complete this application and return to us.

We will use this application to update your plans and notify your participants. Please ensure the application is fully and accurately completed to ensure a smooth renewal of services. Please "Save As" and add your client name to the file name (example: SampleClient_New.COBRA.Client.Form.pdf) so we may easily identify your form.

You can submit your form online at primepay.com/support or fax to 866.382.6272, and we will begin your renewal once your application is received. While renewals may vary, here is an overview of our typical renewal, so you know what to expect:

PHASE	DESCRIPTION
System Update	The COBRA Portals and Member Records will be updated based on your Renewal Application. Please let us know if you are adding, ending or replacing any plans and/or carriers, and if your COBRA population will need to re-elect coverage for the next year.
QB Notification	We will notify Enrolled QBs and Pending QBs of the plan changes. Standard Solution: You are responsible for distributing Open Enrollment packets to your COBRA population. Premium Solution: PrimePay will provide full Open Enrollment packets to the enrolled COBRA participants. To verify which service you have selected, please refer to your COBRA Service Agreement or contact your Client Support Specialist.
Election Changes	We will receive and process enrollment changes for the upcoming new year. We will update our QB records and provide QBs with written confirmation of the new elections and new premium coupons. If you have selected our Standard Solution, you must notify the carrier(s) of any enrollment changes for the upcoming year. Please log into your COBRA Portal and run a Carrier Notification report. If you need assistance, please contact your dedicated COBRA Account Specialist. If you selected our Premium Solution, we will notify the carrier(s) of any enrollment changes for the upcoming year. To verify which service you have selected, please refer to your COBRA Service Agreement or contact your Client Support Specialist.

As always, we are here to help:

WHO NEEDS HELP	WHO TO CONTACT
Client or Broker ONLY	Phone: 877.972.6272 Online: primepay.com/support Fax: 866.382.6272
COBRA Participant	Phone: 855.892.6272 Online: primepay.com/support Fax: 866.382.6272

Section 1 Client Information

Person Completing this Form		
Name:	Title:	Date:
Angela Ku	Account Manager	02/20/2016
Email Address:	Phone Number:	Fax Number:
angela.ku@regions.com	(317) 581-3226	(855) 452-1300

Client Information			
Client Name:			# Enrolled Employees for Billing:
City of Greenwood			235
Effective Date of Changes:	Open Enrollment Start Date:	Open Enrollment End Date:	**Premium Solution Clients: Please provide any inserts for your COBRA Open Enrollment packets (up to 15 pages). PrimePay has a standard cover letter and enrollment form.**
04/01/2016	02/17/2016	03/04/2016	
Will this be an Active or Passive Open Enrollment? Hint: Apply same enrollment rules as active employees.			Is PrimePay Authorized to accept late Open Enrollment elections?
PASSIVE - All elections default to the new year			NO - Late forms should not be accepted.
Please summarize any Plan changes for this open enrollment:			If Plans are being changed, please provide further details:
New plans added that replace existing plans.			Switching medical carriers
Please summarize any Carrier changes for this open enrollment:			If Carriers are being changed, please provide further details:
New carriers added that replace existing plans.			Switching medical carriers

Primary Client Contact for Renewal		
Name:	Title:	Date:
Lisa Bertram	Benefits Coordinator	02/20/2016
Email Address:	Phone Number:	Fax Number:
bertraml@greenwood.in.gov	(317) 887-5604	

Primary Broker Contact for Renewal		
Name:	Title:	Date:
Angie Ku	Account Manager	02/20/2016
Email Address:	Phone Number:	Fax Number:
angela.ku@regions.com	(317) 581-3226	(855) 452-1300

Section 2 Existing Plan(s) Renewal

Below are the plan(s) currently set up in the COBRA Portal. We have pre-filled the information we have into the table.

- If this Plan and Carrier will be offered next year, please provide the new rates. ***If you are changing carriers, please use Section 3 to add the new plan.***
- If the Plan is **ending**, please indicate in question #5.
- If you are **adding** new plans and/or changing carriers, please use Section 3 to add the new plans.

CURRENT PLAN 1	
1. Plan Name	
Advantage Health Solutions Medical Plan	
2. Carrier Name	
Advantage	
3. Group Number	
2000SF	
4. Effective Date	
4/1/2016	
5. Is this Plan **AND** Carrier continuing?	
No, plan should be ended.	
6. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.	
Select from below	
Select from below	
Select from below	
Select from below	
Select from below	

CURRENT PLAN 2	
1. Plan Name	
Delta Dental Plan	
2. Carrier Name	
Delta Dental	
3. Group Number	
0505	
4. Effective Date	
4/1/2016	
5. Is this Plan **AND** Carrier continuing?	
Yes, both are continuing.	
6. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.	
Employee Only	33.97
Employee + Spouse	81.30
Employee + Children	73.92
Employee + Family	121.61
Select from below	

CURRENT PLAN 3	
1. Plan Name	
VSP Vision Plan	
2. Carrier Name	
VSP Vision	
3. Group Number	
476671	
4. Effective Date	
4/1/2016	
5. Is this Plan **AND** Carrier continuing?	
Yes, both are continuing.	
6. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.	
Employee Only	4.25
Employee + Spouse	10.10
Employee + Child	8.75
Employee + Family	12.90
Select from below	

CURRENT PLAN 4	
1. Plan Name	
2. Carrier Name	
3. Group Number	
4. Effective Date	
5. Is this Plan **AND** Carrier continuing?	
Select from below	
6. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.	
Select from below	
Select from below	
Select from below	
Select from below	
Select from below	

CURRENT PLAN 5	
1. Plan Name	
2. Carrier Name	
3. Group Number	
4. Effective Date	
5. Is this Plan **AND** Carrier continuing?	
Select from below	
6. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.	
Select from below	
Select from below	
Select from below	
Select from below	
Select from below	

CURRENT PLAN 6	
1. Plan Name	
2. Carrier Name	
3. Group Number	
4. Effective Date	
5. Is this Plan **AND** Carrier continuing?	
Select from below	
6. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.	
Select from below	
Select from below	
Select from below	
Select from below	
Select from below	

Section 2 Existing Plan(s) Renewal

Below are the plan(s) currently set up in the COBRA Portal. We have pre-filled the information we have into the table.

- If this Plan and Carrier will be offered next year, please provide the new rates. ***If you are changing carriers, please use Section 3 to add the new plan.***
- If the Plan is **ending**, please indicate in question #5.
- If you are **adding** new plans and/or changing carriers, please use Section 3 to add the new plans.

CURRENT PLAN 7	
1. Plan Name	
2. Carrier Name	
3. Group Number	
4. Effective Date	
5. Is this Plan **AND** Carrier continuing?	
Select from below	
6. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.	
Select from below	
Select from below	
Select from below	
Select from below	
Select from below	
Select from below	

CURRENT PLAN 8	
1. Plan Name	
2. Carrier Name	
3. Group Number	
4. Effective Date	
5. Is this Plan **AND** Carrier continuing?	
Select from below	
6. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.	
Select from below	
Select from below	
Select from below	
Select from below	
Select from below	

CURRENT PLAN 9	
1. Plan Name	
2. Carrier Name	
3. Group Number	
4. Effective Date	
5. Is this Plan **AND** Carrier continuing?	
Select from below	
6. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.	
Select from below	
Select from below	
Select from below	
Select from below	
Select from below	

CURRENT PLAN 10	
1. Plan Name	
2. Carrier Name	
3. Group Number	
4. Effective Date	
5. Is this Plan **AND** Carrier continuing?	
Select from below	
6. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.	
Select from below	
Select from below	
Select from below	
Select from below	
Select from below	

CURRENT PLAN 11	
1. Plan Name	
2. Carrier Name	
3. Group Number	
4. Effective Date	
5. Is this Plan **AND** Carrier continuing?	
Select from below	
6. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.	
Select from below	
Select from below	
Select from below	
Select from below	
Select from below	

CURRENT PLAN 12	
1. Plan Name	
2. Carrier Name	
3. Group Number	
4. Effective Date	
5. Is this Plan **AND** Carrier continuing?	
Select from below	
6. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.	
Select from below	
Select from below	
Select from below	
Select from below	
Select from below	

Section 3 NEW Plan(s)

For NEW plan(s) ONLY: You will complete this section if you are adding new plans.
If you have selected our **Premium Solution**, you **must** explain how PrimePay will notify the carrier of COBRA enrollment changes.

NEW PLAN 1				
1. Plan Type:	2. Plan Name:			3. Effective Date:
Medical	Anthem Blue Access PPO			4/1
4. COBRA Group Number:	5. Carrier Name:			6. Participant Customer Service PH#:
	Anthem Blue Cross Blue Shield			
7. Type of Plan funding:	8. Plan written in what state?		9. Conversion avail?	10. Disability COBRA admin fee?
Self Insured	IN		No	50%
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?			12. When does coverage end due to a dependent's Qualifying Event (i.e.,divorce, ineligible dependent, death)?	
On Event Date			On last day of month following QE	
13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.		
Employee Only	$ 872.52	Email update to person below		
Employee + Spouse	$ 1,547.11	Name:	Lisa Bertram	
Employee + Child	$ 1,373.41	Email:	bertraml@greenwood.in.gov	
Employee + Children	$ 1,373.41	Phone #:	(317) 887-5604	
Employee + Family	$ 1,745.53	Fax #:		

NEW PLAN 2				
1. Plan Type:	2. Plan Name:			3. Effective Date:
Medical FSA (EE only dollars)	Flexible Spending Account			4/1
4. COBRA Group Number:	5. Carrier Name:			6. Participant Customer Service PH#:
	Key Benefit Administrators			
7. Type of Plan funding:	8. Plan written in what state?		9. Conversion avail?	10. Disability COBRA admin fee?
Select From Below	IN		Yes	Select From Below
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?			12. When does coverage end due to a dependent's Qualifying Event (i.e.,divorce, ineligible dependent, death)?	
Select From Below			Select From Below	
13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.		
Employee Only		Email update to person below		
Employee + Spouse		Name:	Lisa Bertram	
Employee + Child		Email:	bertraml@greenwood.in.gov	
Employee + Children		Phone #:		
Employee + Family		Fax #:		

Section 3: NEW Plan(s)

For NEW plan(s) ONLY: You will complete this section if you are adding new plans.
If you have selected our **Premium Solution**, you **must** explain how PrimePay will notify the carrier of COBRA enrollment changes.

NEW PLAN 3				
1. Plan Type:	2. Plan Name:			3. Effective Date:
Select From Below				
4. COBRA Group Number:	5. Carrier Name:			6. Participant Customer Service PH#:
7. Type of Plan funding:	8. Plan written in what state?	9. Conversion avail?		10. Disability COBRA admin fee?
Select From Below		Select From Below		Select From Below
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?		12. When does coverage end due to a dependent's Qualifying Event (i.e.,divorce, ineligible dependent, death)?		
Select From Below		Select From Below		
13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.		
Employee Only		Select From Below		
Employee + Spouse		Name:		
Employee + Child		Email:		
Employee + Children		Phone #:		
Employee + Family		Fax #:		

NEW PLAN 4				
1. Plan Type:	2. Plan Name:			3. Effective Date:
Select From Below				
4. COBRA Group Number:	5. Carrier Name:			6. Participant Customer Service PH#:
7. Type of Plan funding:	8. Plan written in what state?	9. Conversion avail?		10. Disability COBRA admin fee?
Select From Below		Select From Below		Select From Below
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?		12. When does coverage end due to a dependent's Qualifying Event (i.e.,divorce, ineligible dependent, death)?		
Select From Below		Select From Below		
13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.		
Employee Only		Select From Below		
Employee + Spouse		Name:		
Employee + Child		Email:		
Employee + Children		Phone #:		
Employee + Family		Fax #:		

Section 3: NEW Plan(s)

For NEW plan(s) ONLY: You will complete this section if you are adding new plans.
If you have selected our **Premium Solution**, you **must** explain how PrimePay will notify the carrier of COBRA enrollment changes.

NEW PLAN 5				
1. Plan Type:	2. Plan Name:			3. Effective Date:
Select From Below				
4. COBRA Group Number:	5. Carrier Name:			6. Participant Customer Service PH#:
7. Type of Plan funding:	8. Plan written in what state?	9. Conversion avail?		10. Disability COBRA admin fee?
Select From Below		Select From Below		Select From Below
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?		12. When does coverage end due to a dependent's Qualifying Event (i.e.,divorce, ineligible dependent, death)?		
Select From Below		Select From Below		
13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.		
Employee + Family		Select From Below		
Employee + Spouse		Name:		
Employee + Child		Email:		
Employee + Children		Phone #:		
Employee + Family		Fax #:		

NEW PLAN 6				
1. Plan Type:	2. Plan Name:			3. Effective Date:
Select From Below				
4. COBRA Group Number:	5. Carrier Name:			6. Participant Customer Service PH#:
7. Type of Plan funding:	8. Plan written in what state?	9. Conversion avail?		10. Disability COBRA admin fee?
Select From Below		Select From Below		Select From Below
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?		12. When does coverage end due to a dependent's Qualifying Event (i.e.,divorce, ineligible dependent, death)?		
Select From Below		Select From Below		
13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.		
Employee + Family		Select From Below		
Employee + Spouse		Name:		
Employee + Child		Email:		
Employee + Children		Phone #:		
Employee + Family		Fax #:		

Section 3: NEW Plan(s)

For NEW plan(s) ONLY: You will complete this section if you are adding new plans.
If you have selected our **Premium Solution**, you **must** explain how PrimePay will notify the carrier of COBRA enrollment changes.

NEW PLAN 7			
1. Plan Type:	2. Plan Name:		3. Effective Date:
Select From Below			
4. COBRA Group Number:	5. Carrier Name:		6. Participant Customer Service PH#:
7. Type of Plan funding:	8. Plan written in what state?	9. Conversion avail?	10. Disability COBRA admin fee?
Select From Below		Select From Below	Select From Below
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?		12. When does coverage end due to a dependent's Qualifying Event (i.e.,divorce, ineligible dependent, death)?	
Select From Below		Select From Below	

13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.	
Employee + Family		Select From Below	
Employee + Spouse		Name:	
Employee + Child		Email:	
Employee + Children		Phone #:	
Employee + Family		Fax #:	

NEW PLAN 8			
1. Plan Type:	2. Plan Name:		3. Effective Date:
Select From Below			
4. COBRA Group Number:	5. Carrier Name:		6. Participant Customer Service PH#:
7. Type of Plan funding:	8. Plan written in what state?	9. Conversion avail?	10. Disability COBRA admin fee?
Select From Below		Select From Below	Select From Below
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?		12. When does coverage end due to a dependent's Qualifying Event (i.e.,divorce, ineligible dependent, death)?	
Select From Below		Select From Below	

13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.	
Employee + Family		Select From Below	
Employee + Spouse		Name:	
Employee + Child		Email:	
Employee + Children		Phone #:	
Employee + Family		Fax #:	

DELTA DENTAL

www.DeltaDentalIN.com

March 8, 2016

Mr. Jon Pierre Fox
Regions Insurance, Inc.
PO Box 2224
2701 Albright
Kokomo, IN 46904-2224

Dear Mr. Fox,

Thank you for your continued support of Delta Dental. We value our relationship with you and your clients, and we appreciate your business. Please find enclosed a copy of the contract effective April 1, 2016 between Delta Dental and City of Greenwood, Client Number 0505-0007, 0100, 0110, etc.

Please review this contract with your client and return the signed contract to Delta Dental at your earliest convenience. If you have any questions or concerns, please contact me at (317) 348-1820. The signed contract may be sent to my attention at:

Delta Dental
Attn: Melinda L Tyo
225 S. East Street, Suite 358
Indianapolis, IN 46202

If we are not in receipt of the signed contract by the effective date, we will consider remittance of payment as acceptance of the contract, and we will begin administering the client's dental benefits accordingly. By permitting us to do so, your client accepts the terms of this contract in full and agrees that this contract is binding, even if you do not return a signed copy of the contract to us.

Again, thank you for your business. We look forward to providing your client with the best dental benefits programs and services available.

Sincerely,

Melinda L Tyo
Account Manager

CC: Ms. Marilyn Allen

DELTA DENTAL

Delta Dental Contract
For
City of Greenwood

This renewal ("Contract") is entered into by and between City of Greenwood (the "Contractor") and Delta Dental Plan of Indiana, Inc., an Indiana non-profit corporation ("Delta Dental"). This is a legally binding contract between the Contractor and Delta Dental and is effective on April 1, 2016, the ("Effective Date"), replacing any previous Declarations, Section I, with the balance of such Contract continued as if fully set forth herein.

SECTION I - DECLARATIONS

The Benefits afforded are only with respect to such benefits as are indicated in this Contract, including the Summary of Dental Plan Benefits. Delta Dental's liability is limited to the Benefits stated herein; subject to all the terms of this Contract having reference thereto. This Declarations Section and the Summary of Dental Plan Benefits supersedes any contrary provision of the subsequent sections of this Contract.

A. **Effective Date:** 12:01 A.M. Standard Time, April 1, 2016

B. **First Renewal Date:** April 1, 2017

C. **Client Number**: 0505-0007, 0100, 0110, 0135, 0150, 0160, 0200, 0210, 0211, 0222, 0272, 0300, 0460, 0485, 0500, 0600, 0750, 0760, 0770, 0790, 0900

D. **Rate(s):**

Subscriber only - $33.97 per month per Subscriber
Subscriber and spouse - $73.92 per month per Subscriber
Subscriber and child(ren) - $81.30 per month per Subscriber
Subscriber, spouse and child(ren) - $121.61 per month per Subscriber

These rates are contingent upon the enrollment of a minimum of 95 percent of the eligible members of the defined group and their eligible dependents with 100 percent of the cost paid by the Contractor. Rates do not include any applicable claims taxes.

These rates assume that claims from nonparticipating dentists will be paid using our national out-of-network fee table.

LISA EDWARDS
NOTARY PUBLIC - INDIANA
COMMISSION #676216
JOHNSON COUNTY
MY COMM. EXP. JANUARY 31, 2024

DELTA DENTAL PLAN OF INDIANA, INC.

BY: Gina L. Galada
President and CEO

DATE: March 8, 2016

CONTRACTOR

BY: Mark W Myers
(Authorized Signature)

Mayor
(Title)

BY: Lisa Edwards
(Witnessed By)

Administrative Assistant
(Title)

DATE: 3-10-16

KR#24232989

DELTA DENTAL

Delta Dental of Michigan, Ohio, Indiana QUALITY ISO 9001 CERTIFICATION

Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 0505-0007, 0100, 0110, 0135, 0150, 0160, 0200, 0210, 0211, 0222, 0272, 0300, 0460, 0485, 0500, 0600, 0750, 0760, 0770, 0790, 0900
City of Greenwood

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Indiana

Benefit Year – April 1 through March 31

Covered Services –

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	80%	80%
Endodontic Services – root canals	80%	80%	80%
Periodontic Services – to treat gum disease	80%	80%	80%
Extractions – removal of teeth	80%	80%	80%
Major Restorative Services – crowns	80%	80%	80%
Other Basic Services – misc. services	80%	80%	80%
Major Services			
Emergency Palliative Treatment – to temporarily relieve pain	50%	50%	50%
Periodontal Maintenance – cleanings following periodontal therapy	50%	50%	50%
Other Oral Surgery – dental surgery other than extractions	50%	50%	50%
Relines and Repairs – to bridges, implants, and dentures	50%	50%	50%
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	No Age Limit	No Age Limit	No Age Limit

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per benefit year.

- Prophylaxes (cleanings) are payable twice per benefit year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per benefit year with no age limit.
- Space maintainers are payable once per area per lifetime for people up to age 13.
- Bitewing X-rays are payable once per benefit year and full mouth X-rays (which include bitewing X-rays) are payable once in any four-year period.
- Sealants are payable once per tooth per lifetime for the occlusal surface of first and second permanent molars up to age 15. The surface must be free from decay and restorations.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,000 per person total per Benefit Year on all services, except oral exams, preventive services, X-rays, brush biopsy, sealants, and orthodontic services. $1,000 per person total per lifetime on orthodontic services.

Deductible – None.

Waiting Period – Employees who are eligible for dental benefits are covered on the date of hire.

Eligible People – Any employee of the Contractor working at least 37.5 hours per week: Retiree (0007), Mayor's Office (0100), Fleet Maintenance (0110), Community Development Services (0135), Information Technology (0150), Human Resources (0160), Clerk (0200), Finance (0210), Airport (0211), Parks and Recreation (0222), Adult Probation (0272), City Court (0300), Fire Department (0460), Motor Vehicle Highway (0485), Board of Works (0500), Police Department (0600), Sanitation Billing (0750), Sanitation Field (0760), Waste Management (0770), Stormwater (0790), Law (0900) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, if applicable. The Contractor pays the full cost of this plan.

Also eligible are your legal spouse and your children under age 26, including your children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled.

If you and your spouse are both eligible for coverage under this Contract, you may be enrolled together on one application or separately on individual applications, but not both. Your dependent children may only be enrolled on one application. Delta Dental will not coordinate benefits if you and your spouse are both covered under this Contract.

Benefits will cease on the date of termination.