September 26, 2023

Dear City of Columbus Retiree,

Welcome to Open Enrollment for 2024! Attached is the enrollment form for medical coverage that will take effect on January 1, 2024.

2024 PPO Retiree Health Insurance Premiums	
Retiree	$583.53
Retiree + One	$1181.81
Family	$1,709.06

2024 HDHP Retiree Health Insurance Premiums	
Retiree	$569.62
Retiree + One	$1,153.66
Family	$1,654.63

If you wish to shop for other insurance coverage to compare, you may contact the CRH Health Insurance Navigator (a free service for city employees and its retirees), who can assist you in determining the best plan option for you and your family. To schedule an appointment, please call (812) 376-5136.

The City of Columbus, Indiana is partially self-insured, and has experienced an increase in healthcare costs this year. We are pleased to be able to offer 50% coverage of those increases, which compares favorably, for example, to some local public agencies whom require retirees to pay 100% of the cost of retiree insurance. This 50% split means that the City of Columbus is splitting the increase in insurance costs equally with retirees.

This form must be completed and returned to Human Resources by **November 1st** in order for you to continue City of Columbus Retiree medical insurance coverage for 2024.

Insurance cards will NOT be issued this year, so if you have lost yours or need a new card, please call SIHO member services at 812-378-7070/800-443-2980 or email SIHO at memberservices@siho.org.

We have some good news: in 2024, estimated to begin in March, the City will be joining the BCSC Health Clinic when it opens in its new NexusPark location. Any covered individual (employee, retiree, dependent on city insurance, spouse on city insurance) who is covered by SIHO insurance through the City of Columbus, Indiana will be able to schedule a visit at the Clinic through MyChart for CRH, and receive care from a nurse practitioner. The visit, and any labs ordered by the nurse practitioner, and some basic medications kept in stock at the clinic are available at no cost to the individual. We believe this will save employees, retirees, and the City money by offering high quality care at a reduced rate. Please stay tuned for more information about the Clinic once it opens to City of Columbus insurance-covered individuals.

There are many questions about PPO (Preferred Provider Organization) vs. HDHP (High Deductible Health Program). Remember that the PPO is the traditional health insurance option. HDHP is a different kind of health insurance, which covers medical expenses after a high deductible is met. It has a lower cost (premium) but requires higher contributions if you get sick, or for most pharmacy expenses. HDHP is good for people who are generally healthy, want to save money on premiums, but want catastrophic health insurance just in case. PPO and HDHP have different types of pharmacy benefits. Generally, you will pay full price for prescription drugs if you opt for HDHP except for certain types of preventative drugs. For more information, please call SIHO member services at 812-378-7070/800-443-2980Enrollment Form Instructions:

- Select a plan - Choose the option of the Preferred Provider Organizations (PPO) plan or the High Deductible plan (HDHP).

- Indicate the election – You may select: Retiree (or Spouse) Only, Retiree + One Dependent, or Family. If you are electing either the Retiree + One or Family option, you must complete the dependent information section. ***If you are covering a spouse, please fill out the spouse verification form, which is enclosed.***

- Dependent information section - Enter the information on your spouse, if covered, on the first line. Enter the information on your dependent children, if covered, on lines two through five.

- Authorization of Coverage - Check 'Authorization' if you wish to enroll in coverage.

- **Note:** The City does not offer insurance to spouses if they have insurance available through their own worksite or Medicare, and the City and SIHO reserve the right to audit this information and request more information. Please be sure to take advantage of Open Enrollment for Medicare or your spouse's insurance at his/her workplace if it is available.

- **Sign and date the enrollment form – the enrollment cannot be processed without your signature.**
  Return the completed enrollment form by November 1st. Forms can be mailed to City of Columbus, Human Resources, 123 Washington Street, Columbus, IN 47201, they can be emailed as attachments to humanresources@columbus.in.gov or they can be hand-delivered to the Human Resources Office in City Hall. If the Human Resources office is closed or staff is in meetings, we have a mail slot in the City Clerk-Treasurer's Office and you may put your completed forms in the mail slot. If we do not receive your enrollment documents online or by mail or by drop-off, we contact you one more time by certified mail, but after that, if you do not enroll, your insurance will END on January 1st.

- If you need help filling out the form, please call 812.376.2570 leave a message if you receive voicemail or ask to make an appointment with Amanda Hunter, who can help you

fill out your form.

If your premiums are paid through your PERF account, please update the enclosed PERF form and sign it so that the correct amount requested from PERF.

When summary plan documents are available (November), you may access them on the city's website, or you may pick up a copy of the Summary Plan Description and other documents. They will be available at: http://www.columbus.in.gov/human- resources/benefits-for-current-employees/ .

In addition to the enrollment form and spouse verification form, we are including the Medicare Part D mandatory notification, and a few other mandatory notifications for employees/retirees covered by insurance.

If you have any questions, you may contact me at 812-376-2570 or Amanda Hunter, Benefits Specialist, ahunter@columbus.in.gov

Sincerely,

Amanda Hunter
Benefits Specialist
Phone: (812) 376-2570
ahunter@columbus.in.gov

AUTHORIZATION FOR INSURANCE PREMIUM DEDUCTION

State Form 54969 (R2 / 2-18)

INDIANA PUBLIC RETIREMENT SYSTEM
1977 POLICE OFFICERS' & FIREFIGHTERS' PENSION & DISABILITY FUND
1 North Capitol Avenue, Suite 001
Indianapolis, IN 46204-2014
Telephone: (844) GO-INPRS (Toll-free)
Fax: (866) 591-9441 (Toll-free)
E-mail: questions@inprs.in.gov
Web site: www.inprs.in.gov

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

INSTRUCTIONS

1. Remove the instruction pages included with this form prior to returning the completed form to the Indiana Public Retirement System (INPRS) at the address shown above.
2. Type or print using black ink. Complete all information and place the Member's name, Social Security number and Pension ID number at the top of each page as requested.
3. This completed form may be delivered to the lobby of INPRS at the address indicated on the form. Lobby hours are 8 a.m. to 5 p.m. on weekdays. The agency is closed on weekends and holidays, including all State-designated holidays.
4. Questions or changes? Call customer service, toll-free, at (844) GO-INPRS, Monday – Friday, 8 a.m.- 8 p.m. EST.

ABOUT THE AUTHORIZATION FOR INSURANCE PREMIUM DEDUCTION

Important Legal Notice

This is a benefit enacted by Congress in 2006. INPRS is proceeding with implementation of the program based on its understanding of the information currently available from the IRS, with the anticipation that the program might require revisions and adjustments as the provisions of the Pension Protection Act are interpreted and clarified. By participating in the program, you acknowledge that changes may be required and that changes could affect your eligibility or the eligibility of your insurance carrier or policy. It may also result in reversal of some transactions. You agree that any benefit or privilege granted under this program is subject to change or revocation, that you will cooperate with any adjustments and that INPRS is not responsible for any consequence of any change to the program, including unexpected tax liability, interest and penalties.

Waiver of Claims

By signing this form, I agree that I will not make any legal claim of any kind against INPRS, its staff and advisors should my participation in this program result in unexpected tax liability to me, including interest and penalties. I understand that my ability to participate in this program is a valuable benefit for which I am willing to agree to this waiver of all claims. I further release INPRS, its staff and advisors from any liability arising from the administration of payments to any insurer.

Eligibility for Tax-free Distributions for Health and Long Term Care Instructions

- Public Safety Officer means an individual serving a public agency in an official capacity, with or without compensation, as a law enforcement officer, as a firefighter, as a chaplain for a police or fire department, or as a member of a rescue squad or ambulance crew.
- Eligible Retired Public Safety Officer (including police, corrections, probation, parole and judicial officers), means an individual who, by reason of disability or attainment of normal retirement age, is separated from service as a public safety officer with the employer who maintains the eligible retirement plan from which distributions are made.
- Normal retirement age for determination of eligibility means a member who has retired with an unreduced benefit.

Insurance Carrier Agreement Information

- You must submit a separate copy of the *Insurance Carrier Agreement* (State Form 55017) for each insurance policy you are designating for direct payment by INPRS.
- The insurance premiums designated will be paid directly to the insurance company or to employers who have self-insured plans by INPRS and the payment will be deducted from your monthly benefit.
- You can use income from more than one retirement plan to pay insurance premiums, but the maximum income exclusion the IRS allows for all plans combined is $3,000 per year. You are responsible for complying with this federal limit and for the consequences if your designated insurance premiums exceed the limit.
- Premium payments will begin the first month after INPRS receives a completed and signed form. Incomplete and unsigned forms will not be processed and you will be notified that you must resubmit the form.

RETIRED MEMBER INFORMATION

Retired member's name		Social Security number *(last 4 digits)**	Pension ID (PID) number
Address	Telephone number with area code		Other telephone number with area code
City	State	ZIP Code	E-mail address

RETIRED MEMBER REQUESTED ACTION

(Select one) ☐ New designation ☐ Change to previously designated policy ☐ Stop previously designated payments

Retired member's name	Social Security number *(last 4 digits)**	Pension ID (PID) number

INSURANCE CARRIER INFORMATION

Insurance carrier name			Group/policy number
SIHO Insurance Services			Retiree
Address	**Telephone number with area code**		**Other telephone number with area code**
417 Washington Street	812-378-7070		812-443-2980
City	**State**	**ZIP Code**	**E-mail address**
Columbus	IN	47201	MemberServices@siho.org
Insurance types *(Select all that apply)* ☑ Medical ☐ Dental ☐ Vision ☐ Long term care			**Premium amount** $

EMPLOYER INFORMATION

Employer name			Submission unit number
City of Columbus			7726-200
Address	**Telephone number with area code**		**Other telephone number with area code**
123 Washington Street	812-376-2510		812-376-2511
City	**State**	**ZIP Code**	**E-mail address**
Columbus	IN	47201	nberkenstock@columbus.in.gov

EMPLOYER REQUESTED ACTION

☐ Insurance carrier change

Current carrier	New carrier

Premium amount to be deducted	As of date *(mm/dd/yyyy)*
$	

☐ Deduction withholding change

Current carrier	New deduction amount	As of date *(mm/dd/yyyy)*
	$	

AUTHORIZED AGENT AFFIDAVIT

As authorized agent for the employer that administers the above named insurance plan, I certify that this individual is a covered participant in the ____ employer insurance plan.
Name of insurance plan

Authorized agent's signature *(Controller, clerk-treasurer, or trustee)*	Authorized agent's name *(printed)*	Date *(mm/dd/yyyy)*
	Natalie Berkenstock	

RETIRED MEMBER ACKNOWLEDGEMENT

1. I hereby authorize INPRS to deduct the monthly insurance premium amount set forth above directly from my monthly pension benefit. I understand that this will result in a decrease in my monthly benefit payment.
2. I understand is my responsibility, as the participant, to inform INPRS of any change related to my health insurance premium deduction including, but not limited to, coverage, insurance company or premium changes. I freely accept this obligation to notify INPRS.
3. I understand it is my responsibility, as the participant, to inform the insurance vendor of any change related to my health insurance premium deduction including, but not limited to, coverage, insurance company or premium changes. I freely accept this obligation to notify the insurance vendor.
4. I understand that INPRS is not responsible for lapsed premiums or lapsed insurance policy coverage or any other coverage or benefit issues that may arise between my insurance carrier and me.
5. I certify that I am eligible to have the designated insurance premiums excluded from taxable income.
6. I understand the maximum amount of insurance premiums excludible from income from all retirement plans is $3000 per year.
7. I take full responsibility for the accuracy and truth of all information I have provided and certify I am entitled to these benefits.
8. I understand that I may not request additional tax-preferred treatment of the applicable exclusion amount (up to $3,000 annually), from any other qualified retirement plans (i.e., Governmental defined benefit plans, 457 plans or 403(b) plans).
9. I understand that INPRS is complying with federal law by withholding insurance premiums from my pension benefits. In doing so, INPRS is only performing an administrative function and is only responsible for payment of premiums, as required by law.
10. I understand that any and all tax implications of my election are my responsibility alone and I agree that I will make no claim against INPRS for consequences of my election.

I have read and I understand the information in this form and its instructions and agree to all the conditions for this election, including the Waiver of Claims (on page 1).

Retired member's signature	Date *(mm/dd/yyyy)*

Retired member's name	Social Security number *(last 4 digits)**	Pension ID (PID) number

FREQUENTLY ASKED QUESTIONS (FAQS) FOR ELIGIBLE RETIRED PUBLIC SAFETY OFFICERS

(This FAQ applies only to members of the 1977 Fund.)

Q1: What does this benefit provide?

A: The HELPS Retirees provision of the Pension Protection Act (PPA) of 2006 allows eligible retired public safety officers to use up to $3,000 per year from their qualified government retirement plan, on a tax-excluded basis, to pay for health insurance or long-term care insurance premiums. In order for you to get the tax-excluded benefit, the money must be paid directly from your pension fund to a health or long-term care insurance company. Further, in order to receive the tax exclusion, you must claim it as a deduction on your IRS Form 1040, as explained in the Form 1040 instructions.

Q2: Who is an eligible retired public safety officer for purposes of the exclusion?

A: Eligible retired public safety officers include those who have separated from service with their INPRS-covered employer due to disability or after reaching normal retirement age. A public safety officer who retires before reaching normal retirement age is not an eligible retired public safety officer, unless the public safety officer retires by reason of disability. In addition, survivors are not eligible to make this election.

Q3: OK, I know that I'm an eligible retired public safety officer. What do I need to do to get this benefit?

A: Contact INPRS at (844) GO-INPRS and ask about the $3,000 tax-excluded benefit for purchasing health insurance or long-term care insurance under the 1977 Fund. The election form is available online at www.INPRS.in.gov. You must submit your election form to the 1977 Fund by December 1 of each year.

Q4: What happens if both my spouse and I are eligible retired public safety officers?

A: Both you and your spouse would be eligible to use up to $3,000 each on a tax-excluded basis to purchase health insurance or long-term care insurance for a total family limit of $6,000. But the premiums would have to be directly deducted for both you and your spouse.

Q5: Under what circumstances are the provisions of HELPS available for retired public safety officers?

A: The favorable tax treatment is available only when an eligible retired public safety officer chooses to have an amount subtracted from his or her distributions from an Eligible Government Plan and that amount is used to pay qualified health insurance premiums. The employer sponsoring the Eligible Government Plan is not required to offer such an election.

Q6: Are eligible retired public safety officers limited in the amount they can exclude from gross income under the HELPS Retirees provision of the PPA?

A: Yes. The aggregate amount that is permitted to be excluded, for any taxable year, from an eligible retired public safety officer's gross income is limited to $3,000. For purposes of applying this $3,000 limitation, distributions with respect to an eligible retired public safety officer that are used to pay for qualified health insurance premiums from all Eligible Government Plans are cumulative.

Q7: Are amounts used to pay qualified health insurance premiums that are excluded from gross income taken into account for purposes of determining the itemized deduction for medical care expenses?

A: No. Amounts used to pay qualified health insurance premiums that are excluded from gross income under 402(l) are not taken into account in determining the itemized deduction for medical care expenses.

Q8: What if the IRS does not agree with my income tax exclusion?

INPRS is released from any unexpected tax liability for the fund member as a result of them making this election.

IC 36-8-8-17.2

INSTRUCTIONS FOR

AUTHORIZATION FOR INSURANCE PREMIUM DEDUCTION

State Form 54969

IMPORTANT

1. Remove the instruction pages included with this form prior to returning the completed form to the Indiana Public Retirement System (INPRS) at the address shown on the form.
2. Type or print using black ink. Complete all information and place the Member's name, Social Security number and Pension ID number at the top of each page as requested.
3. This completed form may be delivered to the lobby of INPRS at the address indicated on the form. Lobby hours are 8 a.m. to 5 p.m. on weekdays. The agency is closed on weekends and holidays, including all State-designated holidays.
4. Questions or changes? Call customer service, toll-free, at (844) GO-INPRS, Monday – Friday, 8 a.m.- 8 p.m. EST.

Entry field	Field description
RETIRED MEMBER INFORMATION	
Retired member's name	Enter the complete name of the retired member.
Social Security number	Enter the last 4 digits of the retired member's Social Security number.
Pension ID (PID) number	Enter the retired member's Pension ID (PID) number.
Address, City, State, ZIP Code	Enter the retired member's street or mailing address.
Telephone number/Other telephone number	Enter telephone numbers including area codes for the retired member.
E-mail address	Enter the retired member's e-mail address, if applicable.
RETIRED MEMBER REQUESTED ACTION	
Select one	• New designation – You must submit a separate copy of the *Insurance Carrier Agreement* (State Form 55017) for each insurance policy you are designating for direct payment by INPRS. • Change to previously designated policy - You must submit a separate copy of the *Insurance Carrier Agreement* (State Form 55017) for each insurance policy you are designating for direct payment by INPRS • Stop previously designated payments – This action ends payment for insurance coverage and therefore, insurance coverage.
INSURANCE CARRIER INFORMATION	
Insurance carrier's name	Enter the complete name of the insurance carrier.
Group/policy number	Enter the complete group insurance or individual policy number.
Address, City, State, ZIP Code	Enter the insurance carrier's street or mailing address.
Telephone number/Other telephone number	Enter telephone numbers including area codes for the insurance carrier.
E-mail address	Enter the insurance carrier e-mail address, if applicable.
EMPLOYER INFORMATION	
Employer's name	Enter the complete name of the employer.
Submission unit number	Enter the submission unit number for the employer.
Address, City, State, ZIP Code	Enter the employer's street or mailing address.
Telephone number/Other telephone number	Enter telephone numbers including area codes for the employer.
E-mail address	Enter the employer's e-mail address, if applicable.
EMPLOYER REQUESTED ACTION	
Insurance carrier change	If this option is selected, complete the items in the following fields.
Current carrier	Enter the name of the current carrier.
New carrier	Enter the name of the new carrier.
Premium amount to be deducted	Enter the premium amount to be deducted from each benefit payment.
As of date	Enter the effective date of this action; format = mm/dd/yyyy.
Deduction withholding change	If this option is chosen, enter the items in the following fields.
Current carrier	Enter the name of the current carrier.
New deduction amount	Enter the amount to be deducted for insurance from each benefit payment.
As of date	Enter the effective date of this action; format = mm/dd/yyyy.
AUTHORIZED AGENT AFFIDAVIT	
Name of insurance plan	Enter the name of the insurance plan. This should be the same as the carrier named earlier on the form.
Authorized agent's signature	The authorized agent must be a controller, clerk-treasurer, or trustee. The authorized agent must sign and date this form.
Authorized agent's name	The authorized agent's printed name must be included
Date	The authorized agent must include the date the form was signed; format = mm/dd/yyyy.
RETIRED MEMBER ACKNOWLEDGEMENT	
Retired member's signature	The retired member must sign and date this section of the form.
Date	The retired member must include the date the form was signed; format = mm/dd/yyyy.

INSTRUCTIONS FOR

AUTHORIZATION FOR INSURANCE PREMIUM DEDUCTION

State Form 54969

HELPFUL INFORMATION			
	INPRS/PERF	**INTERNAL REVENUE SERVICE**	INDIANA DEPARTMENT OF REVENUE
Telephone numbers	(844) GO-INPRS Toll-free	(800) 829-1040 Toll-free	(317) 233-4018 Indianapolis local
	(866) 591-9441 Fax Toll-free	(800) 829-4477 TeleTax	(317) 232-2240 Tax questions
		(800) 829-4059 TDD (hearing impaired)	(317) 233-4952 TDD (hearing impaired)
			(317) 233-2329 Fax
Web site	www.inprs.in.gov	www.irs.gov	www.in.gov/dor

SIHO INSURANCE SERVICES

P.O. Box 1787 • Columbus, IN 47202-1787

columbusindiana
unexpected.unforgettable.

CITY OF COLUMBUS INDIANA

RETIREE 2024 ENROLLMENT FORM

DEPARTMENT NAME:

RETIREE

ENROLLMENT INSTRUCTIONS:

This enrollment form lists your 2024 benefit options and corresponding premium amounts. Use this form to elect your benefit coverage. **PLEASE PRINT ALL INFORMATION AND SIGN FORM IN BLUE OR BLACK INK.**

RETIREE- *PLEASE PROVIDE THE FOLLOWING INFORMATION:*

RETIREE LAST NAME: ______________________ RETIREE FIRST ______________________

SS NUMBER: ______________ BIRTH DATE: (MO/DAY/YR) __________ GENDER: M ☐ F☐

STREET ADDRESS: ______________ CITY: ______________ STATE: ____ ZIP: __________

PHONE NUMBER: ______________ EMAIL ADDRESS: ______________________

DEPARTMENT: ______________ HIRE DATE: __________ RETIREMENT DATE: __________

BENEFIT ELECTIONS- MEDICAL

ELECTION	RETIREE OR RETIREE SPOUSE ONLY	RETIREE PLUS 1 DEPENDENT	FAMILY
PPO PLAN MONTHLY:	☐ $583.53	☐ $1181.81	☐ $1,709.06
HDHP PLAN MONTHLY:	☐ $569.62	☐ $1153.66	☐ $1654.63

INSERT TOTAL MONTHLY PREMIUM AMOUNT: $ __________

Last name, First, MI (Specify last name if different)	Gender M/F	Relationship to subscriber	Birthday Mo./Day/Yr.	Social Security Number
02-Spouse				
03-Child				
04-Child				
05-Child				
06-Child				
07-Child				

I certify that the information furnished above is complete and accurate to the best of my knowledge. In addition, I understand that if there are any changes in the information, it is my responsibility to report this to my employer at the time of the change. I accept responsibility for any claims paid incorrectly because of the incomplete or inaccurate information provided on this form.

Signature:____

AUTHORIZATION OF COVERAGE

AUTHORIZATION: ☐ I authorize hospitals, physicians or other providers of service to furnish SIHO (acting as the TPA for my employer), upon request, any and all reports and records or copies thereof concerning any illness, injury or condition for which service was provided to me or my dependents under age 26 after this date, together with like reports and records or copies thereof of earlier services for purposes of processing this application and for purposes of determining the eligibility of any claim for payment or the propriety of any payment made. In recognition of the legitimate interest of my employer in reviewing historical data setting forth the volume, nature and costs of healthcare services paid by my employer, I hereby authorize SIHO to provide my employer plan with information relating to medical services and treatment rendered to me and/or my dependents under age 26 listed on this application.

I, for myself and for those of my eligible dependents listed above, hereby agree to abide by the rules, regulations and terms of my employer's group health plan documents as such documents may be amended. I shall cooperate and assist SIHO in the exercise of the subrogation and coordination of benefits rights of my employer's plan. I certify that the information furnished is true and complete to the best of my knowledge and I understand that inaccurate information provided regarding my coverage on other plans, my spouse's access to other coverage, or dependents' coverage under employer provided plans may affect my of claims and my access to insurance. By initially here, I acknowledge and agree to these rules.

Initials_____________

Retiree Signature: ________________________ Print Name:__________________________

Date:___________________________________

Spousal Employment Verification Form

The City of Columbus offers health care coverage to qualifying retirees and their dependents. Some conditions may affect coverage for you and your dependents. The City of Columbus Health Plan has a Working Spouse Rule. <u>If your spouse is employed and eligible for insurance through his/her employer, the spouse will not be eligible for this plan</u>.

Please answer all questions and attach to your enrollment form. <u>If you do not wish to cover your spouse on your plan, you do not need to complete this form.</u>

Is your spouse employed?

Yes If yes, please list the employer's name ____

No

Does your spouse's employer offer medical insurance?

Your waiver on the application for insurance allows SIHO to independently verify eligibility with the employer to audit this status.

Yes

No

Is your spouse eligible for coverage under the employer's medical plan?

If your spouse is not eligible, a statement from your spouse's employer that verifies that coverage is not available is required.

Yes Date your spouse becomes eligible under their employer's plan _______________

No

Is your spouse currently covered on the medical plan offered by the employer?

Yes If yes, effective date of coverage ________________

No

Please provide the name, address and telephone number of your spouse's medical insurance carrier or plan.

I certify that the information furnished above is complete and accurate to the best of my knowledge. I understand that the City may request more information and I have a duty to provide that information, SIHO may at any time audit this information and independently verify this information and any inaccuracy may affect coverage for past or future claims. I understand that providing false information on City forms may affect my status as an employee at the City of Columbus. In addition, I understand that if there are any changes in the information, it is my responsibility to immediately report this to my employer/former employer at the time of the change (example: if my spouse becomes employed and is offered health insurance, I must immediately provide this information to the Benefits Coordinator at the City). I accept responsibility for any claims paid incorrectly because of the incomplete or inaccurate information provided on this form and I acknowledge my duty to accurately complete this form.

____

Signature Date

____

Print Name