benefit guide

April 1, 2020 –
March 31, 2021

Wabash County

Benefits Overview

Wabash County Government is proud to offer a comprehensive benefits package to eligible full-time employees who work 35 hours per week and have 30 days of service. The benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs. For any questions please contact Human Resources at **260.563.0661, ext. 1290**.

You share the costs of some benefits (medical and vision) and Wabash County Government provides other benefits at no cost to you (life, accidental death & dismemberment, short-term disability). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

Benefit Plans Offered

- Medical
- Life Insurance (Term Life)
- Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life (Term Life)
- Short-Term Disability
- Vision
- Aflac Critical Illness
- Aflac Dental
- Aflac Cancer
- Aflac Accident
- Aflac Short-Term Disability
- Life Insurance (Whole Life)

Eligibility

You and your dependents are eligible for benefits on the 31st day of employment.

Eligible dependents are your spouse, children, and disabled dependents of any age.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event*. If you experience a qualifying event, you must contact HR within 31 days.

*e.g., marriage, birth, divorce, death or involuntary loss of coverage

Working Spouse Rule

If a spouse is eligible for coverage under their employer's medical plan, the spouse must enroll in that coverage. For your spouse to be eligible for the Wabash County plan, they must not have access to other employer sponsored coverage.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

Medical Benefits

Administered by Anthem

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at a lower cost.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Wabash County Government.

With our PPO, you may select where you receive your medical services. If you use in-network providers, your costs will be less.

	In-Network	Out-of-Network
Annual Deductible	$1,000 single / $2,000 family	$3,000 single / $6,000 family
Annual Out-of-Pocket Maximum (includes deductible)	$3,500 single / $7,000 family	$7,000 single / $14,000 family
Coinsurance	80%	60%
Doctor's Office		
Primary Care Office Visit	$30 copay	40% after deductible
Specialist Office Visit (including Urgent Care)	$50 copay	40% after deductible
Wellness Care (routine exams, x-rays/tests, immunizations, well baby care and mammograms)	100%, no deductible	40% after deductible
Hospital Services		
Emergency Room	$250 copay, (waived if admitted) and 80% after deductible	
Inpatient and Outpatient Professional Services (Include but not limited to: Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams)	80% after deductible	40% after deductible
Inpatient Facility Services (Unlimited days except for: 60 days for physical medicine/rehab 90 days for skilled nursing facility)	80% after deductible	40% after deductible
Outpatient Surgery Hospital/ Alternative Care Facility	80% after deductible	80% after deductible
Other Outpatient Services (including but not limited to): Non-Surgical Outpatient Services (MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services) Home Care Service – 100 visits (Network/Non-network combined and excludes IV Therapy) Durable Medical Equipment and Orthotics Prosthetic Devices Physical Medicine Therapy Day Rehabilitation Programs	80% after deductible	40% after deductible
Hospice Care	100% no deductible	100% no deductible
Ambulance Service	80% after deductible	80% after deductible
Mental Health Services		
Inpatient Services	80% after deductible	40% after deductible
Physician Home and Office Visits (PCP/SPC)	$30 copay	40% after deductible
Outpatient Services	80% after deductible	40% after deductible

	In-Network	Out-of-Network
Substance Abuse Services		
Inpatient Services	80% after deductible	40% after deductible
Physician Home and Office Visits (PCP/SPC)	$30 copay	40% after deductible
Outpatient Services	80% after deductible	40% after deductible
Other Services		
Maternity Services	Paid as any other service	Paid as any other service
Muscle Manipulation Services 12 annual maximum benefit (combine network and non-network limits apply)	80% after deductible	40% after deductible
Physical Therapy 20 visits annual maximum benefit (combine network and non-network limits apply)	80% after deductible	40% after deductible
Cardiac Rehabilitation 36 visits annual maximum benefit (combine network and non-network limits apply)	80% after deductible	40% after deductible
Pulmonary Rehabilitation 20 visits annual maximum benefit (combine network and non-network limits apply)	80% after deductible	40% after deductible
Occupational Therapy 20 visits annual maximum benefit (combine network and non-network limits apply)	80% after deductible	40% after deductible
Speech Therapy 20 visits annual maximum benefit (combine network and non-network limits apply)	80% after deductible	40% after deductible
Prescription Drugs		
Retail—Generic Drug (30-day supply)	$10	50%, Minimum $70
Retail—Formulary Drug (30-day supply)	$35	50%, Minimum $70
Retail—Nonformulary Drug (30-day supply)	$70	50%, Minimum $70
Mail Order—Generic Drug (90-day supply)	$20	Not covered
Mail Order—Formulary Drug (90-day supply)	$70	Not covered
Mail Order—Nonformulary Drug (90-day supply)	$210	Not covered
Specialty Drugs	25% to a max of $300	Not covered

Telemedicine Benefit from Anthem – Live Health Online (www.livehealthonline.com)

Live Health Online is simply a new way to access qualified doctors. All Live Health Online doctors:	Live Health Online doctors can treat many medical conditions, including:	It is a convenient and affordable option for quality care.
» Are practicing PCPs, pediatricians, and family medicine physicians » Average 15 years experience » Are U.S. board-certified and licensed in your state » Are credentialed every three years, meeting NCQA standards	» Cold and flu symptoms » Allergies » Sinus problems » Ear infection » Urinary tract infection » Respiratory infection » Skin problems » And more!	» When you need care now » If you're considering the ER or urgent care for a non-emergency issue » On vacation, on a business trip, or away from home » For short-term prescription refills

Life and Accidental Death & Dismemberment Insurance

Insured by One America

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed. The county provides basic life insurance of $25,000 at no cost to you.

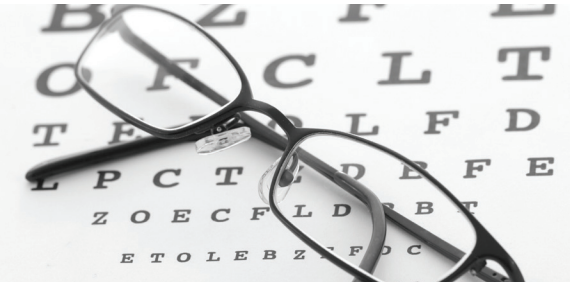
Accidental Death & Dismemberment (AD&D) Insurance

Accidental Death & Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Wabash County Government provides AD&D coverage of $25,000 at no cost to you. This coverage is in addition to your county-paid life insurance described above.

Voluntary Vision Insurance

Administered by EyeMed

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.



Your coverage from an EyeMed doctor

	In-Network (any VSP provider)	**Out-of-Network** (any qualified non-network provider of your choice)
Eye Exam — once every 12 months	$10 copay; covered in full	Up to $30
Lenses — once every 12 months		
Single Vision Lenses	$15 copay; covered in full	Up to $25
Lined Bifocal Lenses	$15 copay; covered in full	Up to $40
Lined Trifocal Lenses	$15 copay; covered in full	Up to $60
Lenticular Lenses	$15 copay; covered in full	Up to $60
Frames — once every 24 months	$0 copay; Up to $130	Up to $65
Contact Lenses — once every 12 months if you elect contacts instead of lenses/frames	Up to $105	Up to $84

Voluntary Life and AD&D Insurance

Insured by OneAmerica

You may purchase life insurance in addition to the county-provided coverage. You may also purchase life insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage (up to $150,000 or five times your salary, and up to $25,000 for your spouse) without answering medical questions if you enroll when you are first eligible.

Employee—Up to five times your salary in increments of $1,000; $500,000 maximum amount

Spouse—Up to $25,000 in increments of $1,000

Children—Up to $10,000

Additional Benefits

Paid Time Off Benefits (100% county paid):

Holidays	12-14 days per year
Vacation	5-20 days per year (based on service)
Personal	2 days per year
Sick	6 days per year
Bereavement	3 days for immediate family
Jury Duty	20 days per 2 year period
Workers Compensation	Medical and Disability benefits
Unemployment Benefits	

Other Benefits (100% county paid):

- Short-Term Disability
- Employee Assistance Plan – Bowen Center (4 free counseling sessions)
- Pension Plan – PERF (pension and annuity savings account)

Other Benefits Offered (county sponsored):

- Deferred Compensation Plan – Hoosier S.T.A.R.T. (IRA and Roth)

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

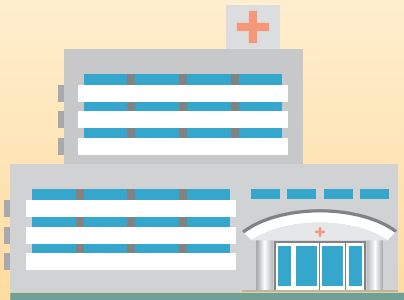
Benefit	Administrator	Phone	Website/Email	Group #
Medical	Anthem	800.296.4118	www.anthem.com	228606
Voluntary Vision	EyeMed	800.521.3605	www.eyemedvisioncare.com	9877317
Term Life	OneAmerica	800.553.5318	www.oneamerica.com	612550
Whole Life	Boston Mutual	800.669.2268	pfinnell@gregoryappel.com	06872
Voluntary Life and AD&D Insurance	OneAmerica	800.553.5318	www.oneamerica.com	612550
Dental	Aflac	260.358.8157	kris@krishittlerinsurance.com	0DMK1
Voluntary Short-Term Disability	Aflac	260.358.8157	kris@krishittlerinsurance.com	0DMK1
Critical Illness	Aflac	260.358.8157	kris@krishittlerinsurance.com	9876
Cancer	Aflac	260.358.8157	kris@krishittlerinsurance.com	0DMK1
Accident	Aflac	260.358.8157	kris@krishittlerinsurance.com	0DMK1

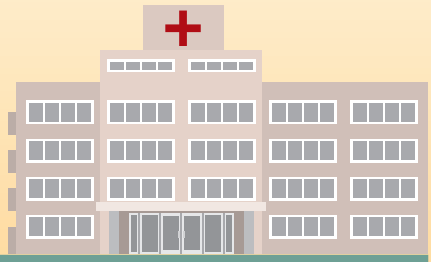
Employee Contributions

Benefit Plan	Biweekly
Medical/Rx	
Employee	$91.79
Employee + Spouse	$195.80
Employee + Child(ren)	$190.31
Family	$224.16
Vision Rates	
Employee	$3.17
Employee + Spouse	$6.03
Employee + Child(ren)	$6.35
Family	$9.33

Anthem BlueCross BlueShield

Be a smart shopper – it pays to compare





Hospital 1	Procedures	Hospital 2
$3,000	Bronchoscopy	$5,000
$300	Chest CT scan	$1,000
$25,000	Hip replacement	$36,000
$25,000	Knee replacement	$37,000

Sample cost comparison*

Different doctors and hospitals may charge different amounts for the same service. So shop around using the **Estimate Your Cost** tool to see costs based on your own benefits. You can also compare the quality of different procedures.

Know your costs before you get care

Go to **anthem.com** and log in to use the **Estimate Your Cost** tool. Search for the procedure you need and the tool will help guide you.

For even quicker cost comparison, use the **Anthem Blue Cross and Blue Shield** mobile app.

Download on the App Store | Google play

* These rates are national averages for the services listed. Your experience may be different depending on your specific plan, the services you receive and the health care provider. Rates as of 2014.

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At home or on the go, doctors and mental health professionals are here for you.

Starting 1/1/2018 you can also meet with board-certified Psychiatrists using LiveHealth Online!

When you're not feeling well you can get the support you need easily using LiveHealth Online. Whether you have a cold, you're feeling anxious or need help managing your medication, doctors and mental health professionals are right there, ready to help you feel your best. Using LiveHealth Online you can have a video visit with a board-certified doctor, psychiatrist or licensed therapist from your smartphone, tablet or computer from home or anywhere.

On LiveHealth Online, you can:

- **See a board-certified doctor 24/7.** You don't need an appointment to see a doctor. They're always available to assess your condition and send a prescription to the pharmacy you choose, if needed.[1] It's a great option when you have pink eye, a cold, the flu, a fever, allergies, a sinus infection or another common health issue.
- **Visit a licensed therapist in four days or less.**[2] Have a video visit with a therapist to get help with anxiety, depression, grief, panic attacks and more. Schedule your appointment online or call **1-888-548-3432** from **8 a.m. to 8 p.m.,** seven days a week.
- **Consult a board-certified psychiatrist within two weeks.**[3] If you're over 18 years old, you can get medication support to help you manage a mental health condition. To schedule your appointment call **1-888-548-3432** from **8 a.m. to 8 p.m.,** seven days a week.

You've got access to affordable and convenient care

Your Anthem plan includes benefits for video visits using LiveHealth Online, so you'll just pay your share of the costs — usually $49 or less for medical doctor visits, and a 45-minute therapy or psychiatry session usually costs the same as an office mental health visit.

Sign up for LiveHealth Online today – it's quick and easy

Go to **livehealthonline.com** or download the app and register on your phone or tablet.

Download on the App Store | ANDROID APP ON Google play

Anthem | LiveHealth ONLINE

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1 Prescription availability is defined by physician judgment and state regulations. Visit the home page of livehealthonline.com to view the service map by state.
2 Appointments subject to availability of a therapist.
3 Prescriptions determined to be a "controlled substance" (as defined by the Controlled Substances Act under federal law) cannot be prescribed using LiveHealth Online. Psychiatrists on LiveHealth Online will not offer counseling or talk therapy. Appointments subject to availability.

Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

If you're a retiree or have coverage that complements your Medicare benefits, your employer sponsored health plan may not include coverage for online visits using LiveHealth Online. Check your plan documents for details. You can still use LiveHealth Online, but you may have to pay the full cost of a visit. Online visits using LiveHealth Online may not be a covered benefit for HRA and HIA+ members.

Know where to go for care, before you need it

Knowing where to go if you get sick or hurt can save you lots of time and money, and help you get the best medical care. How do you choose where to go when the unexpected happens?

The emergency room (ER) shouldn't be your first stop — unless there's a true emergency.

Go to the nearest emergency room or call **911** if:

- There is a lot of pain or bleeding.
- You think a bone is broken.
- You are having trouble breathing.
- You think the problem might get a lot worse if you don't get help right away.
- You think the problem could kill you.
- There was no warning before your symptoms started.

Not sure what to do? Call your doctor.

He or she can help you find the best place to get care.

If you need help but it isn't an emergency, here are your options:

- **Call your doctor.** He or she can help you decide whether you should go to an urgent care or come into the office.
- **Call 24/7 NurseLine.** A registered nurse will help you decide what to do.
- **Go to a retail health clinic.** These are small offices in drug stores or other large stores. They are open on weekends, evenings and most holidays. If the clinic can't help you, they'll tell you where to go next and you won't have to pay.
- **Go to an urgent care center.** Urgent care is for when you need to be treated right away, but your problem isn't serious. These centers are typically open late at night, and on weekends and holidays.
- **Visit a doctor using LiveHealth Online.** Board-certified doctors are available 24/7 to see you via video using your computer or mobile device. Use LiveHealth Oline for common health issues like the cold, a flu, allergies and pink eye.

Anthem BlueCross BlueShield

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When do I need emergency or urgent care?

While urgent and emergency situations are both serious, urgent care is for problems that need attention right away, but are not severe or life-threatening.

You should go to urgent care for things like an earache, sore throat, rash, sprained ankle, flu or a fever up to 104°. A higher fever might be an emergency.

Am I covered for emergency care?

Most health plans cover medical care at an ER for situations like the ones listed on the other side. But you may be responsible for the ER costs if you visit an ER when it's not an emergency.

Am I covered for urgent care?

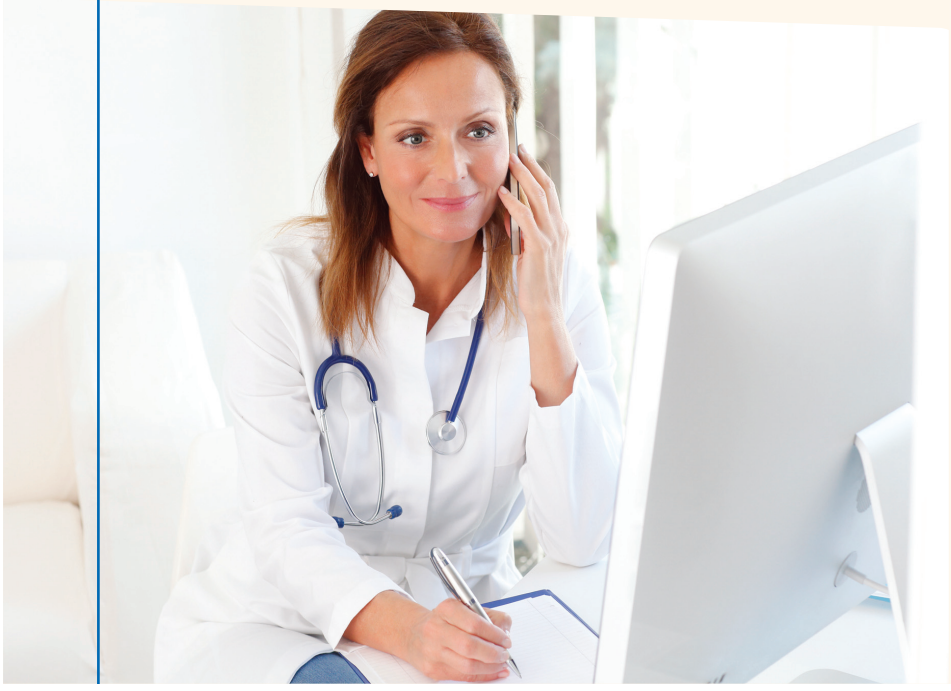
Urgent care is usually covered if it's provided in a non-ER setting by a provider in the network. If you need urgent care and your doctor can't see you right away, use your best judgment to decide what to do.

To find a doctor, retail health clinic or urgent care center in your plan, go to **anthem.com**, select **Find a Doctor** and follow the instructions to find health professionals near you.

Questions?

We are here to help, so give us a call at the Member Services number on your ID card. You can also log in to **anthem.com** for a closer look at your benefits.

Your doctor can help you find the best place to get care. He or she can help you decide whether you should come into the office, go to the ER, or schedule an appointment to see a specialist.



Anthem BlueCross BlueShield

A Guide to Your Explanation of Benefits (EOB)

So, what's an EOB?
The EOB explains how your benefits pay for your care – it's not a bill. We mail you an EOB when a doctor or hospital files a claim for your care. For every doctor visit or service, your EOB explains the services, the cost of those services and the benefits from your plan that may be applied to the care you received. It's as simple as that.

You may not always get an EOB in the mail. For example, if you only need to pay a copay for a doctor visit or other service, we won't send you an EOB. But you can still view your medical EOBs online at **anthem.com**. You can even choose to go completely paperless for all medical EOBs by selecting **Go Paperless** in your account profile.

How much do I owe?
When you get an EOB, this is probably the first thing you look for. Our new EOBs make it easier to find all the information you need to help you better manage your health care services and what you spend for care.

On the upper right-hand side is a sample of an EOB you might get. We've put boxes around key areas of the EOB, and included explanations.* To find out more about your EOB, see the other side of this flier.

Section 1 - Claim summary

Services provided for: Talulla Tests (1)
Member's ID: 123A45678
Relationship: Account Holder
Date Prepared: 01/01/2013

Claim number: 3456789123456
Services provided by: Joseph Smith, MD
Patient account: 98765432198761
Claim receipt date: 01/01/13
Explanation of payment: (2)

(3) Date of service / Procedure code / Service received / Reason code	Charges $ (4) Total charged	− Your discounts	= Total for services	Payments $ (5) Your health plan pays	Another insurance pays	You pay: Copay	Deductible	Coinsurance	Services not covered
Office visit 11/1/12 99213	144.00	- 62.51	81.49	81.49	0.00	0.00	0.00	0.00	0.00
Subtotal	**144.00**	**- 62.51**	**81.49**	**81.49**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Total	**144.00**	**- 62.51**	**81.49**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Without an Anthem plan, your cost would have been $144.00. You saved $144.00. **Total you pay: $0.00**

You can learn more about the services listed by calling member services at **800-421-1880**. We can tell you the diagnosis and treatment codes included on your claim, along with the descriptions for those codes.

Claim summary

1 – Personal information. Shows who received the service, the relationship to the cardholder and when the EOB was prepared.

2 – Claim tracking details. Contains information that you can use to track the specific service and what the payment is for.

3 – Service details.
Includes the date of service, the service received, any explanation of payment reason codes and the procedure code.

4 – Charges.
Here's what you'll find in the *Charges* section:

- The amount billed by the provider and your network discounts (if any). Note: If you receive Medicare/complementary services, this will be the amount billed to Medicare.
- How much is owed to the provider, plus any coinsurance or copays you owe for this claim.

5 – Payments.
Here's what you'll find in the *Payments* section:

- How much your health plan owes the provider.
- How much another insurance plan pays. This section only appears if we are the secondary insurance carrier.
- Your copay. This is a flat fee you pay for a doctor visit or covered service.
- How much you need to pay as part of your deductible (the amount you must pay for covered health care costs before your benefits are paid).
- Your coinsurance. This is the percentage of the health care costs you pay after meeting the deductible. For example, an insurance plan might pay 80%, while you pay 20%.
- The cost for services that aren't covered or a cost that is over what your benefits cover.

*Please note that some of these sections may not appear on your EOB. Also, your EOB may include a check.

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Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are **not** currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **877.KIDS.NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx 800.541.5555
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711
FLORIDA – Medicaid
http://flmedicaidtplrecovery.com/hipp 877.357.3268
GEORGIA – Medicaid
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, ext. 2131
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid http://www.indianamedicaid.com | 800.403.0864

IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563
KANSAS – Medicaid
http://www.kdheks.gov/hcf/default.htm 800.792.4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
http://www.maine.gov/dhhs/ofi/public-assistance/index.html 800.442.6003 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
http://www.mass.gov/eohhs/gov/departments/masshealth 800.862.4840
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp (Under ELIGIBILITY tab, see "what if I have other health insurance?") 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005

MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/oii/hipp.htm 603.271.5218 | Toll-Free:800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm 800.692.7462

RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
https://www.coverva.org/hipp/ Medicaid: 800.432.5924 CHIP: 855.242.8282
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
http://mywvhipp.com/ 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf 800.362.3002
WYOMING – Medicaid
https://wyequalitycare.acs-inc.com/ 307.777.7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

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

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

Important Notice About Your Prescription Drug Coverage and Medicare (for those reaching Medicare eligibility age)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Anthem has determined that the prescription drug coverage offered by the plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your- existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current medical coverage be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period or Qualifying Event.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

Note: You'll get this notice each year, also may request a copy of this notice at any time.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

» Visit **www.medicare.gov**.

» Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help , call **1.800.MEDICARE (1.800.633.4227)**. TTY users should call **1.877.486.2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1.800.772.1213** (TTY **1.800.325.0778**).

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

As a participant in the "Plan," you are eligible for certain healthcare benefits. In the course of providing these benefits to you, the Plan may receive and maintain some of your medical information. Federal law requires that the Plan protect the privacy of, generally, medical information that identifies you and relates to your past, present or future health or condition, the provision of healthcare to you, or the payment for healthcare received by you ("protected health information" or "PHI"). The Plan may hire other companies ("Business Associates") to help provide healthcare benefits to you. These Business Associates may also receive and maintain your medical information.

The Plan is required to abide by the terms of the Notice currently in effect. The Plan may change its privacy practices and the terms of this Notice at any time. Changes will be effective for all of your medical information received or created by the Plan. If the Plan changes its policies regarding the protection of your medical information) the Plan will mail you a new notice of privacy practices that incorporates any changes within 60 days. The Plan will also will post a new notice on its internet website.

How the plan may use and disclose your medical information

The Plan may use and disclose your medical information without your written permission for the following purposes:

For treatment. While the Plan does not directly participate in decisions regarding your health treatment, the Plan may disclose medical information it has created or received for treatment purposes. For example, the Plan may disclose your medical information to your doctor, at the doctor's request, for his or her treatment of you.

For payment. The Plan or one of its Business Associates may use or disclose your medical information to pay claims for medical services provided to you or to provide eligibility information to your doctor when you receive medical treatment.

For healthcare operations. The Plan may provide your medical information to our accountants, attorneys, consultants,- and others in order to make sure we are complying with federal law. Also, your medical information may be used or disclosed to assess the quality of healthcare that you receive or to assist the Plan in the management of its performance of administrative activities.

To you, your personal representative or others involved in your healthcare. The Plan may provide your medical information to you and your legal representative. The Plan may also provide medical information to a person, including family members, other relatives, friends or others identified by you and acting on your behalf, so long as you do not object and the information is directly relevant to such person's involvement in your healthcare. For this purpose, a person acts on your- behalf by being involved in the provision and/or payment of your healthcare.

As required by law. For example, the Plan may disclose your medical information to comply with workers compensation laws or other similar laws.

To business associates. The Plan may disclose your medical information to its business associates so that they may perform the services that the Plan has asked them to perform. The Plan requires that these entities appropriately safeguard your medical information.

For health-related benefits. The Plan or one of its business associates may contact you about treatment alternatives or other health benefits or services that may be of interest to you.

For other uses and disclosures permitted by law such as:

» To public health authorities for public health purposes (e.g. the reporting of communicable diseases);

» To state agencies handling cases of abuse, neglect, or domestic violence;

» To a government agency authorized to oversee the healthcare system or government programs (e.g. determining eligibility for public benefits);

» To law enforcement officials for limited law enforcement purposes (e.g., to locate a missing person or suspect);

» To a coroner, medical examiner, or funeral director about a deceased person (e.g., to identify a person);

- To an organ procurement organization under limited circumstances;
- For research purposes in limited circumstances (e.g., if identifying information is removed or a research board has approved the use of the information);
- To avert a serious threat to your health or safety or the health or safety of others;
- To military authorities if you are a member of the armed forces or a veteran of the armed forces;
- To federal officials for lawful intelligence, counterintelligence, and other national security purposes;
- To an executor or administrator of your estate; and
- To any other persons and/or entities authorized under law to receive medical information.

For any other use or disclosure of your medical information, the Plan must have your written authorization. You may cancel your written authorization for the use and disclosure of any or all of your medical information unless the Plan has taken action in reliance on your permission.

Some uses and disclosures that require your authorization are those with respect to:

- Psychotherapy notes, except:
  - to carry out the following treatment, payment, or healthcare operations:
    - use by the originator of the psychotherapy notes for treatment;
    - use or disclosure by the provider for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or
    - use or disclosure by the Plan to defend itself in a legal action or other proceeding brought by the individual; or
  - with respect to a use or disclosure that is:
    - required by the Secretary to investigate or determine the Plan's compliance;
    - permitted to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law and in accordance with HIPAA;
    - to a health oversight agency for oversight activities authorized by law with respect to the oversight of the originator of the psychotherapy notes;
    - to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law; or as necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- Marketing except if the communication is in the form of:
  - a face-to-face communication made by a Plan to an individual; or
  - a promotional gift of nominal value provided by the Plan.

  If the marketing involves :financial remuneration, to the Plan from a third party, the authorization must state that such remuneration is involved.
- Sale of PHI.

The Plan is prohibited from using or disclosing PHI that is genetic information of an individual for underwriting purposes. The Plan is required by law to maintain the privacy of PI-II, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI.

Your Rights

You may make a written request to the Plan to do one or more of the following concerning your medical information received or created by the Plan and/or the Plan's business associates:

- The right to request restrictions on certain uses and disclosures of medical information; however, the Plan is not required to agree to such request unless:
  - the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law; and
  - the PHI pertains solely to a healthcare item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the Plan in full.
- The right to receive confidential communications of medical information by alternative means or at alterative locations.
- The right to inspect and copy medical information.
- The right to amend medical information.
- The right to receive an accounting of disclosures of medical information.
- The right, even if you have agreed to receive this notice electronically, to obtain a paper copy of this from the Plan upon request.

Although the Plan will utilize its best efforts to comply with your request, the Plan may legally deny your request under certain circumstances. The Plan will notify you of the reason for the denial and you will get a chance to respond. The Plan may not deny a request to communicate with you in confidence by a different means or location if the current means or location used by the Plan endangers you. The Plan may, however, request payment for any additional expenses it incurs to comply with your request. Your request to communicate by a different means or location must be in writing, include a statement that disclosure of all or part of the medical information by the current means could endanger you, specifically state the different means or location by which you would like the Plan to communicate with you, and continue to allow the Plan to pay claims.

Complaints

If you feel as if your privacy rights have been violated, you may file a written complaint with:

Wabash County Government
ATTN: Human Resources
1 West Hill Street, Suite 103
Wabash, IN 46992
260.563.0661

You may also send a written or electronic complaint to the Secretary of the Department of Health and Human Services. The complaint must state the name of the entity that is the subject of the complaint and describe the act or omissions believed to be in violation of law. A complaint must be filed within 180 days of when you knew or should have known that the act or omission complained of occurred. The Plan may not retaliate against you if you file a complaint.

More Information

If you would like more information about this Notice, please contact Human Resources at **260.563.0661, ext 1290**.

Special Enrollment Rights

Group plans are required to provide special enrollment periods for individuals who do not enroll in the plan at the first opportunity because of other coverage, and subsequently lose this other source of coverage. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the plan, provided you request such enrollment in writing within 31 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and you dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Fraud Against the Plan

You are responsible for the accuracy of the dependent information you provide. You should check to make sure you are in compliance with the spouse and dependent eligibility rules. Insurance fraud increases the cost of medical, dental, life and other benefits. If you knowingly, and with intent to defraud or deceive any benefit plan, file a statement of claim containing any false, intentionally incomplete or misleading information, or if you allow such a claim to be submitted on behalf of you or one of your dependents, you will be responsible for the consequences. These consequences include, but are not limited to, retroactive termination of coverage and/ or reimbursement to the plan for payments made from the plan.

The plan also may choose to pursue civil and/or criminal action.

Women's Health and Cancer Rights Act

On October 21, 1998, Congress passed a bill called the Women's Health and Cancer Rights Act. This new law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed,
- Surgery/reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Physical complications during all stages of mastectomy, including lymph edemas

In addition, the plan may not:

- Interfere with a woman's rights under the plan to avoid these requirements, or
- Offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles and copays consistent with other coverage provided by the plan.

Newborns' and Mothers' Health Protection Act of 1996

The Medical Plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, the Medical Plans may not, under federal law, require that a provider obtain authorization from the Plans for prescribing a length of stay less than 48 hours (or 96 hours, as applicable).

HIPAA Special Enrollment Rights

Initial Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the District's Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan—your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact your plan administrator.

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

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