benefit guide

April 1, 2025 –
March 31, 2026

Wabash County Government

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 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)
- Vision
- 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 provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Medical Benefits

Administered by Unified Group Services

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.

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

Exclusive Provider Organization (EPO) three-tier plan design that allows the greatest savings by seeing EPO providers in Wabash as well as continued access to a wide variety of locations.

	EPO Facilities and PPO Providers	PPO Facilities	Out-of-Network
Annual Deductible	$750 single / $1,500 family	$1,750 single / $2,500 family	$3,750 single / $4,500 family
Annual Out-of-Pocket Maximum (includes deductible and all copays)	$3,000 single / $6,000 family	$6,000 single / $9,000 family	Unlimited
Coinsurance	20%	30%	50%
Doctor's Office			
Primary Care Office Visit	$30 copay	Not Available	50% after deductible
Specialist Office Visit	$50 copay	Not Available	50% after deductible
Urgent Care	$50 copay; Copay includes office visit charge only. All other services are subject to deductible and coinsurance		
Wellness Care (routine exams, x-rays / tests, immunizations, well baby care and mammograms)	Paid at 100%	Paid at 100%	50% after deductible
Hospital Services			
Inpatient Hospital	20% after deductible	30% after deductible	50% after deductible
Emergency Room	$250 copay, then 20% (waived if admitted)		
Diagnostic X-Ray / Lab	20% after deductible	30% after deductible	50% after deductible
Skilled Nursing Care (Outpatient / Inpatient) (150 days per calendar year combined with inpatient rehabilitation)	20% after deductible	30% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	30% after deductible	50% after deductible
Other Outpatient Services (including but not limited to): Non-Surgical Outpatient Services (MRIs, PET and CAT scans) Home Care Service – 120 visits (Network / Non-Network combined) Durable Medical Equipment Prosthetic Devices	20% after deductible	30% after deductible	50% after deductible
Hospice Care	Paid at 100%	30% after deductible	50% after deductible
Ambulance Service	EPO deductible, then 20%		
Mental Health Services			
Inpatient Services	20% after deductible	30% after deductible	50% after deductible
Outpatient Services	$30/visit	Not Available	50% after deductible

	EPO Facilities and PPO Providers	PPO Facilities	Out-of-Network
Substance Abuse Services			
Inpatient Services	20% after deductible	30% after deductible	50% after deductible
Outpatient Services	$30/visit	Not Available	50% after deductible
Other Services			
Maternity Services	20% after deductible	30% after deductible	50% after deductible
Muscle Manipulation Services limited to 12 annual visits per calendar year	$50 copay	$50 copay	50% after deductible
Physical and Occupational Therapy limited to 40 annual visits per calendar year	20% after deductible ($50 copay if performed in office)	30% after deductible ($50 copay if performed in office)	50% after deductible
Cardiac Rehabilitation limited to 36 annual visits per calendar year	20% after deductible	30% after deductible	50% after deductible
Pulmonary Rehabilitation limited to 20 annual visits per calendar year	20% after deductible	30% after deductible	50% after deductible
Speech Therapy limited to 20 annual visits per calendar year	20% after deductible	30% after deductible	50% after deductible
Prescription Drugs			
Retail—Generic Drug (30-day supply)	$10	$10	50%
Retail—Formulary Drug (30-day supply)	$35	$35	50%
Retail—Non-Formulary Drug (30-day supply)	$70	$70	50%
Mail Order—Generic Drug (90-day supply)	$20	$20	Not covered
Mail Order—Formulary Drug (90-day supply)	$70	$70	Not covered
Mail Order—Non-Formulary Drug (90-day supply)	$210	$210	Not covered
Specialty Drugs (30-day supply)	25% to a max of $300		50% Retail; Not covered for Mail Order

wellbridge surgical

Discover WellBridge Surgical: A New Solution In Indiana

WellBridge Surgical delivers high-quality surgical services with up-front, all-inclusive, pricing. WellBridge is *what quality health care SHOULD cost.*

Need Surgery?
Free at WellBridge*

Step 1: Call
Provide medical and insurance information
Surgeon information provided

Step 2: Consult
Surgeon office will call to schedule consultation at surgeon's office
Determine if surgery needed

Step 3: Schedule
Schedule Surgery

Step 4: Pre-Surgery
Confirm surgery date and details for surgery day
Discuss medical history and answer any questions

Step 5: Surgery
Day of Surgery

Step 6: Post-Surgery
Call from WellBridge Surgical 24 hours post surgery

Highly-skilled Surgeons

We hand-pick our Surgical Team from some of the most prominent surgeons in their fields. They are the same top-tier surgeons, performing the same procedures at other Indiana hospital networks. The only difference is that you get the benefits of their talents at dramatically reduced prices.

Procedures Include:

- General Surgery
- ENT (Ear Nose Throat)
- General Orthopedics
- Hand Surgery
- Urology
- Gynecology
- Podiatry
- Plastic Surgery
- GI Procedures like colonoscopy

**Employees will receive a $200 visa debit card on day of surgery to cover travel costs.*

317.480.4200 | Info@wellbridgesurgical.com | wellbridgesurgical.com

Visit wellbridgesurgical.com for a full current price list.

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. Wabash 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 provides AD&D coverage of $25,000 at no cost to you. This coverage is in addition to your Wabash County life insurance described above.

Dependent Life

At an additional cost, you have the opportunity to purchase Spouse (under age 70) basic life insurance of $10,000 and Child (6 months or older) basic life insurance of $5,000 ($1,000 for birth to under 6 months). Eligible dependent child(ren) are covered from birth to 19 years or 25 if a full-time student.

Voluntary Life and AD&D Insurance

Insured by OneAmerica

You may purchase life insurance in addition to the Wabash 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

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

INNOVATIVE ANSWERS FOR SAVVY SPENDERS

Keep an eye on your money

MEMBERS-ONLY SPECIAL OFFERS

You deserve special savings just for being an EyeMed member. So there's a page on eyemed.com/member that only registered members like you can see. It's a mix of the latest discounts and extra savings that give your benefits a boost. So you can keep your eyes healthy and save some cash while you're at it.

New offers for 2025

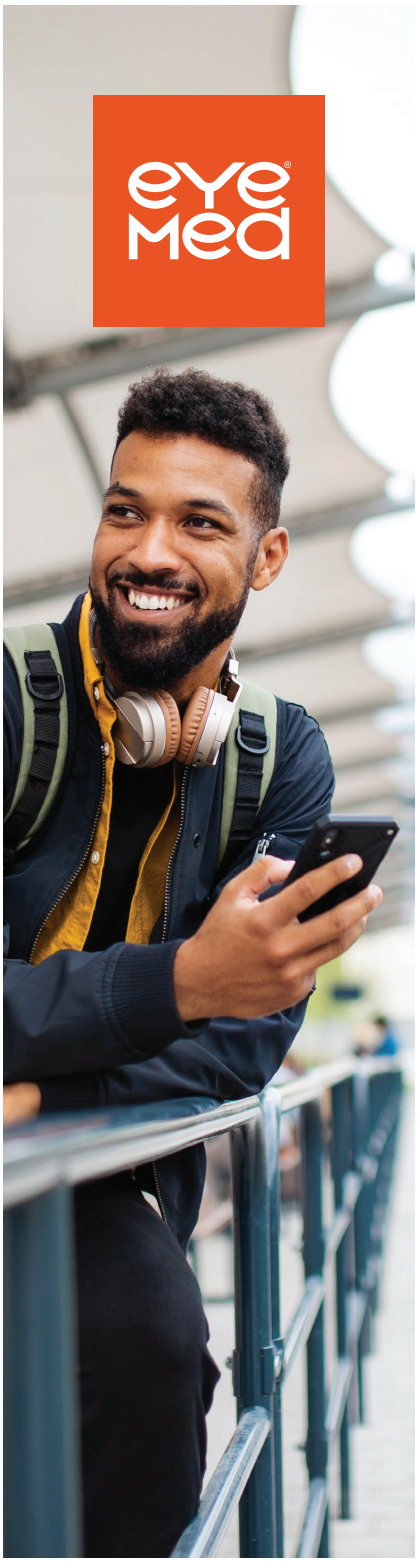
More offers are added throughout the year. Be sure to check for the latest savings before visiting your provider.

GLASSES.COM	LasikPlus, TLC Laser Eye Centers, The LASIK Vision Institute	PEARLE VISION
GET **$30** off on Blue Light lens treatment at **Glasses.com***	USE UP TO **$1,000** toward LASIK at LasikPlus®, TLC Laser Eye Centers and The LASIK Vision Institute** Call 1-800-988-4221 or visit eyemedlasik.com	GET **$50** off a complete pair (frames and lenses) at Pearle Vision***
Expires: 12/31/2025	Expires: 12/31/2025	Expires: 12/31/2025
Get details	Get details	Get details

UNLOCK YOUR OFFERS IN MINUTES

1. **Visit eyemed.com/member or download the EyeMed app**
2. **Register and sign in**
3. **Select Special Offers and shop the savings**

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL



INNOVATIVE ANSWERS FOR SMART SHOPPERS

Smarter tools for smarter shoppers

KNOW BEFORE YOU GO

At EyeMed, we want to help you the get the most from your vision benefit. That's why we've enhanced our Know Before You Go tool. Now, it's easier to estimate your out-of-pocket costs, so you can be a savvy shopper.

- **New look and feel–**Navigate with ease.
- **Designed for all devices–**Use your phone, tablet or PC. The tool's responsive design adjusts to any screen size.
- **More flexibility–**Easily edit your selections or start over.
- **Spotlight on special offers–**Find more ways to save with your vision benefit.
- **Provider search–**Quickly find an eye doctor near you.

Along with these new features, the tool still offers simple definitions and interactive examples of common products and add-ons. Plus, you get a range of costs with each selection you make.

TRY IT OUT FOR YOURSELF

1. **Register or log into your account at member.eyemedvisioncare.com** and click the Estimate Costs tab.
2. Select the service you want an estimate for: "Eye Exam" or "Vision Products" for glasses or contacts.
3. Choose your frame type – are you more fashion or function? Basic or premium?
4. Explore a variety of lens types, options and add-ons. Get details for each product.
5. Get a clear summary of your estimated out-of-pocket costs based on your selections.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

PDF-XXXX-X-XXX

INNOVATIVE ANSWERS FOR SAVVY SPENDERS

*Get an additional $30 off Blue Light lens treatment on top of your EyeMed benefits at Glasses.com. Enter code EYEMED30BL in your cart when checking out with your EyeMed vision benefit on Glasses.com website. Complete pair (frame and lenses) purchase required. Cannot be combined with any other offers, previous purchases, readers or non-prescription sunglasses. Single use only. Valid prescription required. Savings applied to lenses, after insurance benefits are applied. $200 minimum purchase order. No cash value. Void where prohibited. Offer expires 12/31/2025. Offer not valid in the state of Texas.

**Must mention this promotion and be treated by December 31, 2025 to qualify. $1,000 off for both eyes on standard Wavelight price, $500 off for one eye. Cannot be combined with any other offers. See details at eyemedlasik.com.

***Coupon required at time of purchase. Buy a complete pair (frame and lenses) (minimum purchase may apply) of eyeglasses or prescription sunglasses at tag price and receive $50 toward your purchase. May be combined with any vision care or insurance plans/benefits, select offers or discounts. Consult your vision care or insurance plans/benefits for details. Valid prescription required. Discount off tag price. Savings applied to lenses. Excludes certain brands including Michael Kors, Retail Collection, Maui Jim, Costa, Prada, Jimmy Choo, Ferrari, and wearable electronics. May exclude Ray-Ban, Oakley, and Persol. Not valid on previous purchases, contact lenses, accessories, readers, or non-prescription sunglasses. Valid at participating U.S locations. Taxes not included. Void where prohibited. Additional exclusions may apply. See store for details. Limit one coupon per customer. No cash value. Offer ends: 12/31/25. Corporate Discount Code: 10007. Offer not valid in the State of Texas.

Discounts are not insurance.

PDF-2412-M-727

Additional Benefits

Paid Time Off Benefits (100% Wabash 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% Wabash County paid):

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

Other Benefits Offered (Wabash 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	Unified Group Services	765.608.6680	www.unifiedgrp.com	4694
Voluntary Vision	EyeMed	800.521.3605	www.eyemedvisioncare.com	9877317
Term Life	OneAmerica	800.553.5318	www.oneamerica.com	612550
Whole Life	Boston Mutual	877.624.2249	David.long@kingview-benefits.com	06872
Voluntary Life and AD&D Insurance	OneAmerica	800.553.5318	www.oneamerica.com	612550
Dental	Aflac	260.433.4948	molly_kurtz@u.s.aflac.com	0DMK1
Voluntary Short-Term Disability	Aflac	260.433.4948	molly_kurtz@u.s.aflac.com	0DMK1
Cancer	Aflac	260.433.4948	molly_kurtz@u.s.aflac.com	0DMK1
Accident	Aflac	260.433.4948	molly_kurtz@u.s.aflac.com	0DMK1

Employee Contributions

Benefit Plan	Biweekly
Medical / Rx	
Employee	$110.36
Employee + Spouse	$236.67
Employee + Child(ren)	$229.48
Family	$267.72
Vision Rates	
Employee	$3.17
Employee + Spouse	$6.03
Employee + Child(ren)	$6.35
Family	$9.33
Dependent Basic Life	
$1.38	

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 July 31, 2024. 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: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
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 Health Insurance Buy-In Program (HIBI) https://www.mycohibi.com/ HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program Family and Social Services Administration http://www.in.gov/fssa/dfr/ | 800.403.0864 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid 800.338.8366 Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki 800.257.8563 HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kynect.ky.gov | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
https://mn.gov/dhs/health-care-coverage/ 800.657.3672
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 | Email: HHSHIPPProgram@mt.gov
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/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 15218 | Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 800.356.1561 CHIP: http://www.njfamilycare.org/index.html 800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)

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
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program 800.440.0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) https://medicaid.utah.gov/upp/ | Email: upp@utah.gov | 888.222.2542 Adult Expansion: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/ CHIP: https://chip.utah.gov/
VERMONT – Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid and CHIP
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2024, 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 1/31/2026)

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**).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you maybe 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).

Date:	4/1/2025 – 3/31/2026
Name of Entity/ Sender:	Wabash County Government
Contact:	Human Resources
Address:	1 West Hill Street, Suite 202 Wabash, IN 46992
Phone Number:	260.563.0661

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 202
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.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you are or have recently become covered under Wabash County Government's group health plan (the Plan). This notice contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description (SPD) or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

» Your hours of employment are reduced, or

» Your employment end for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

» Your spouse dies;

» Your spouse's hours of employment are reduced;

» Your spouse's employment ends for any reason other than his or her gross misconduct;

» Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

» You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

» The parent-employee dies;

» The parent-employee's hours of employment are reduced;

» The parent-employee's employment ends for any reason other than his or her gross misconduct;

» The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

» The parents become divorced or legally separated; or

» The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is termination of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You must Give Notice of Some Qualifying Events

Under the law, the employee or a family member has the obligation to inform the Plan Administrator, at the address shown below, of a divorce, legal separation, or a child losing dependent status within 60 days of the latest of 1) the date the qualifying event occurs; 2) the date on which there is a lose of coverage; or 3) the date on which you are informed, either through the SPD or General COBRA Notice, of your obligation to provide notice. The employer has the responsibility to notify the Plan Administrator of the employee's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, spouses, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the

18-month period of continuation coverage. You must notify the Plan Administrator within 60 days of the latest of 1)the date the Social Security Administration deems you or your covered dependent disabled; 2) the date on which the qualifying event occurs; 3) the date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or 4) the date on which the Qualified Beneficiary is informed of both the responsibility to provide the notice and the plan's procedures for providing such notice. Such notice must be provided before the end of the 18 month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. Notification must be given to the Plan Administrator within 60 days of the latest of 1) the date the qualifying event occurs; 2) the date on which there is a lose of coverage; or 3) the date on which you are informed, either through the SPD or General COBRA Notice, of your obligation to provide notice. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption.

Early Termination of COBRA Coverage:

However, the law also provides that continuation coverage may be cut short for any of the following five reasons:

1. The company no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered - after the date he or she elects COBRA coverage - under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA coverage;
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follow:

If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

How Much Does COBRA Continuation Coverage Cost:

Under the law, you may have to pay all or part of the premium for your continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium. At the end of the 18-month, 29-month or 36-month continuation coverage period, qualified beneficiaries will be allowed to enroll in an individual conversion health plan provided a conversion health plan is available to active employees.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If You Have Questions

For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act , and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at . (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov** and **www.dol.gov/ebsa**.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members, marital or dependent status. Please notify the Plan Administrator. .

Plan Contact Information

Wabash County Government
Human Resources
One West Hill Street, Suite 202
Wabash, IN 46992
260.563.0661

Notes

Notes

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

DCN25BGWC