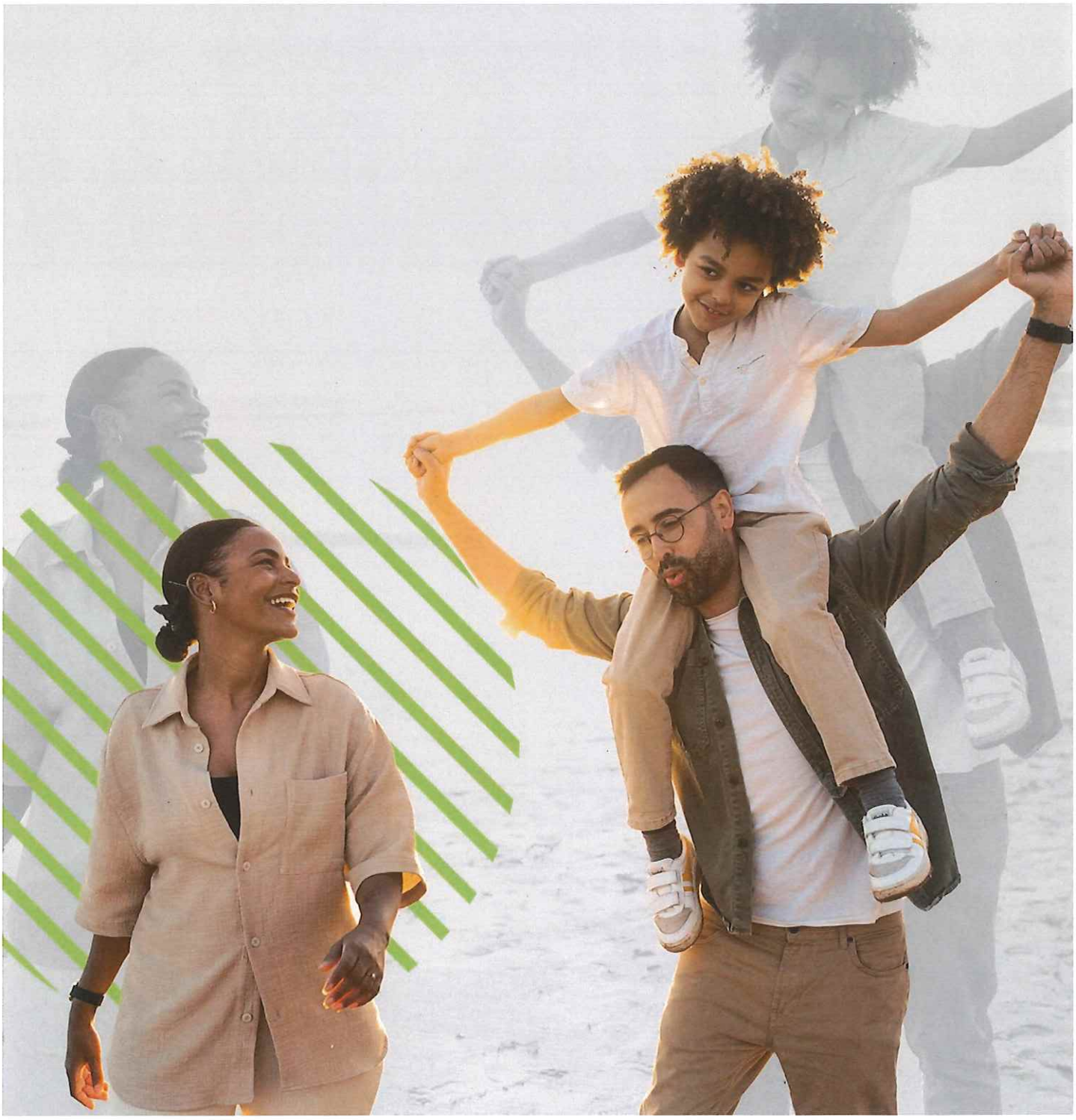
2024 BENEFITS GUIDE



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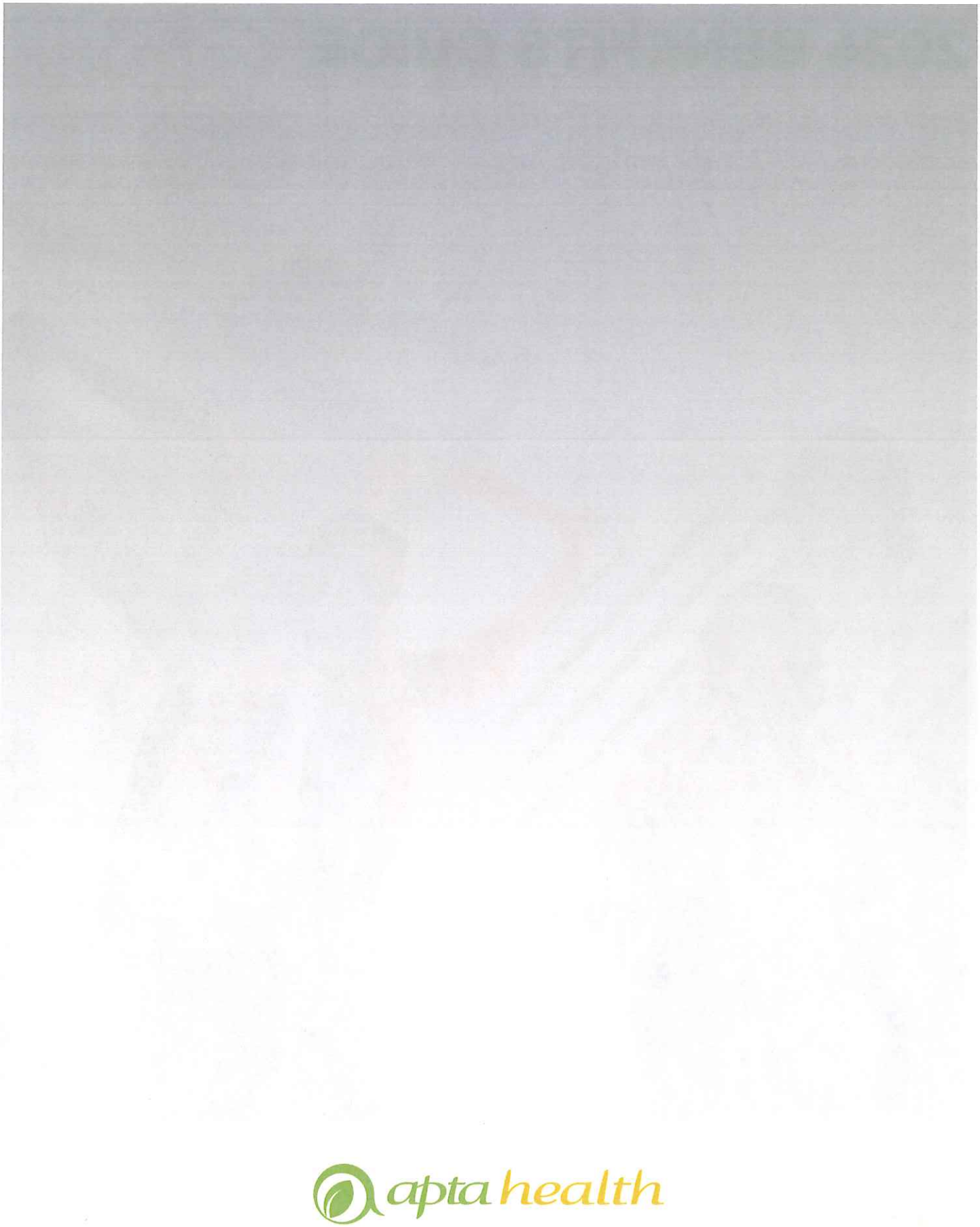

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This Benefits Guide is an overview of the benefits provided by Porter County Government . It is not a Summary Plan Description or Certificate of Insurance. If a question arises about the nature and extent of your benefits under the plans and policies, or if there is a conflict between the informal language of this Benefits Guide and the contracts, the Summary Plan Description and Certificates of Insurance will govern. Please note that the benefits in your Benefits Guide are subject to change at any time. The Benefits Guide does not represent a contractual obligation on the part of Porter County Government .

WHAT IS APTA HEALTH?

Dear Apta Health Member,

Congratulations! You are a member of an exciting new way of managing your healthcare. Your employer has chosen Apta Health to bring amazing benefits that are usually reserved for Fortune 500 Companies to its employees. The Apta Health program brings together some of the best healthcare vendors in the country and combines them into a single package to help you get the best care at the best prices.

Care Coordination is at the heart of our program. This unique approach to healthcare allows you access to a real, live person to talk to about your health concerns and is available **completely free of charge** whenever you need help. Think of your Care Coordinators as healthcare warriors that will fight for you to make sure you get the best care possible! They are based in Ohio, USA and available Monday through Friday, 8:30 AM to 10:00 PM Eastern Time. You can call them for anything from replacing a lost ID card, to help finding an in-network physician, to help with an upcoming medical procedure, and questions or issues with your medical bills. They are also available through your company's custom web portal, or through the Quantum Health App on the Apple App Store or Google Play. Your Care Coordinators are the best place to start whenever you have questions or need help.

Apta Health includes the standard components that you would expect from a healthcare program like a network of doctors and hospitals as well as prescription drug insurance. Your company may also choose additional components that further enhance your coverage. These additional components are included and explained in this benefit guide.

The great news is that your care coordinators are trained experts in all your benefits and will guide you through your benefit decisions. Your care coordinators will help you move along your healthcare journey and make the process as smooth as possible.

We hope you will enjoy your healthcare benefits and wish you a happy and healthy year!

Sincerely,

The Apta Health Team

MEET YOUR APTA CARE COORDINATORS

Care Coordinators are an expert team of nurses, patient services representatives and benefits specialists who are ready to help you before, during and after any health event. Think of Care Coordinators as your personal healthcare team. They fight hard to help you save money and make sure you get the best possible care for you and your family. You can contact them via the website, toll-free number listed on your ID card, or through the Quantum Health app.

CARE COORDINATORS CAN HELP WITH:

Ordering ID Cards
Claims, billing and benefit questions
Finding in-network providers
Nurse coaching to help you stay or get healthy
Reducing out-of-pocket costs
Anything that can make the healthcare process easier for you

CARE COORDINATORS ARE MOBILE

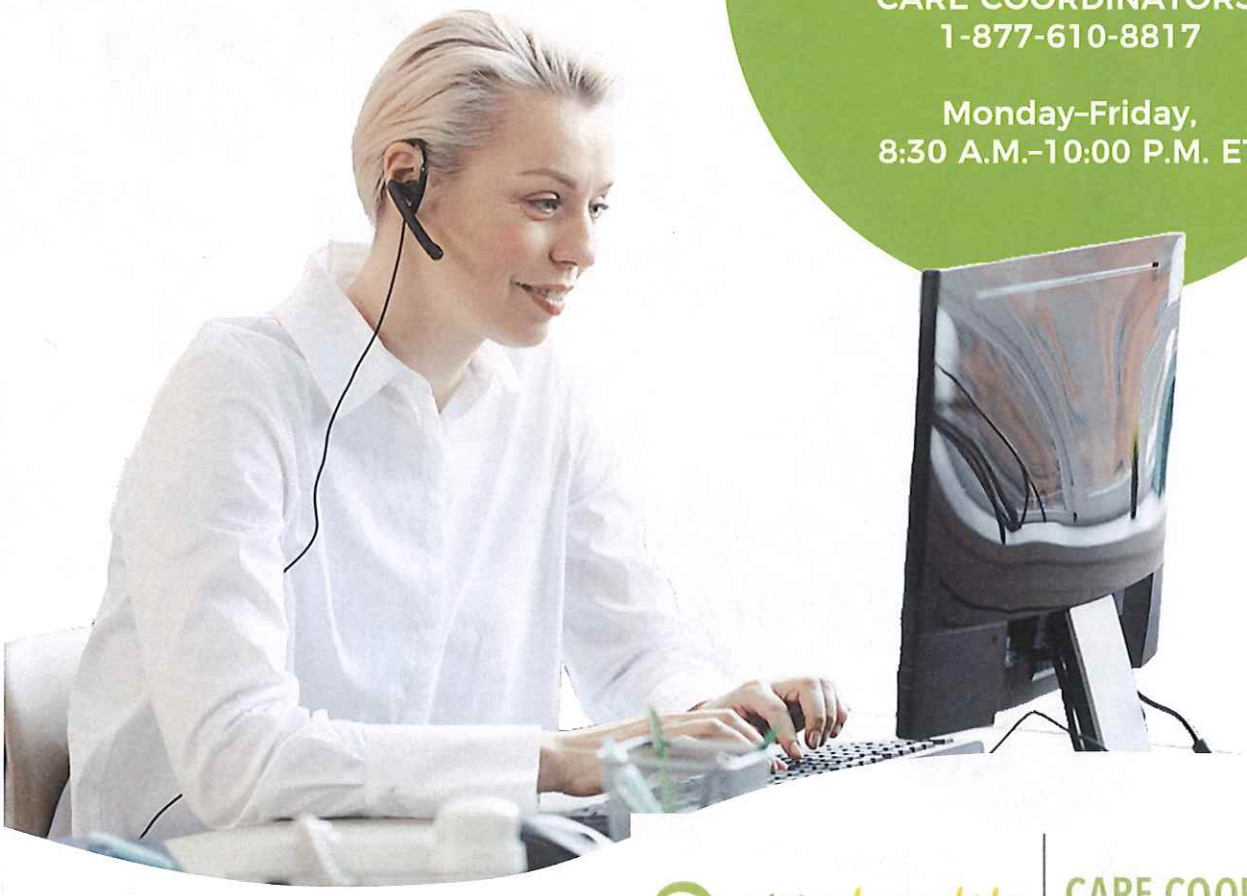
Download the Quantum Health mobile app that lets you:

- Find in-network providers
- Access your ID card
- Check claims information
- Schedule a call with a Care Coordinator
- Send texts/chat with Care Coordinators
- And so much more

ACCESS YOUR APTA HEALTH WEBSITE:
https://portercounty.myaptahealth.com

CONTACT YOUR CARE COORDINATORS:
1-877-610-8817

Monday–Friday,
8:30 A.M.–10:00 P.M. ET



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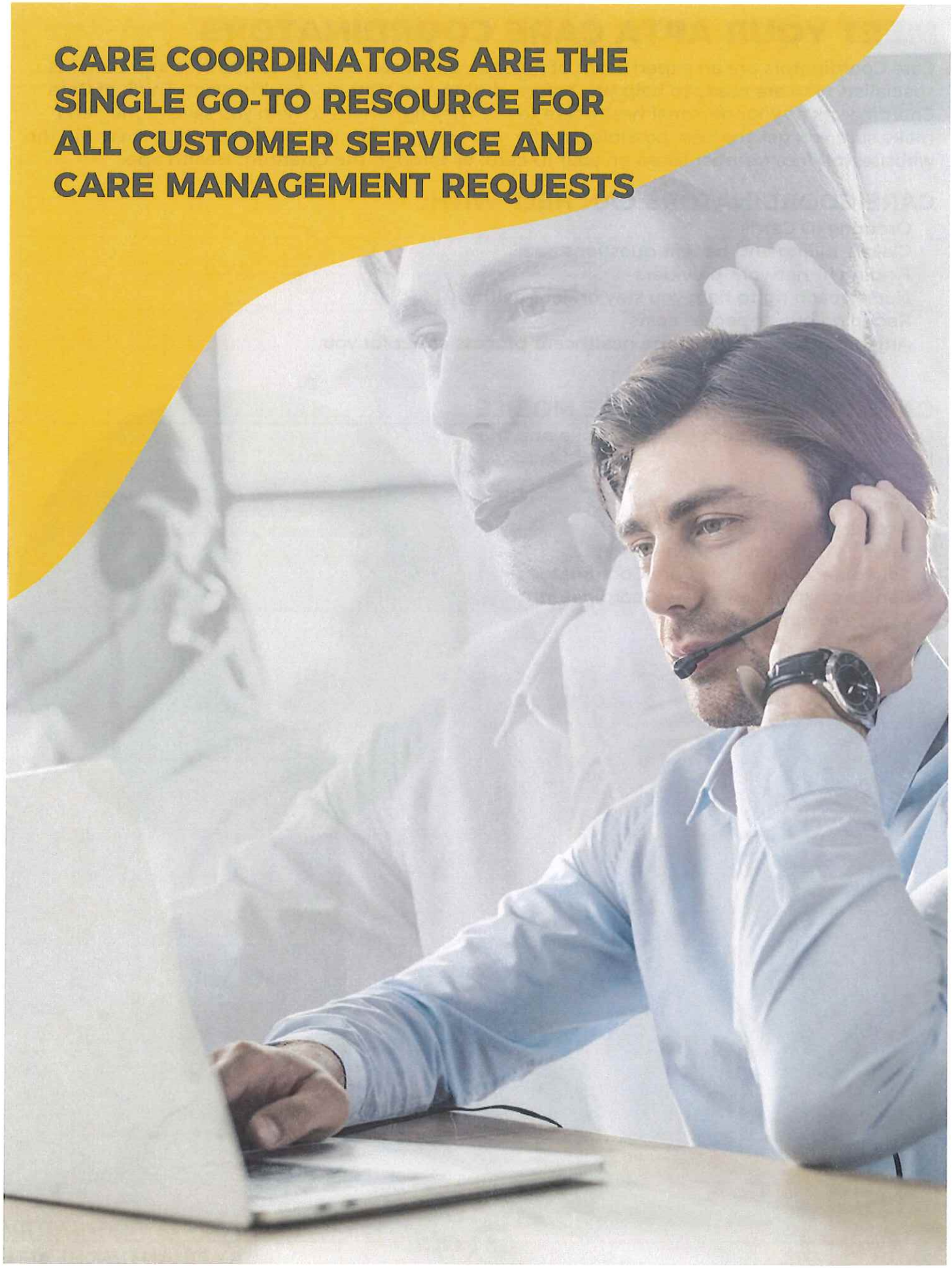
CARE COORDINATORS ARE THE SINGLE GO-TO RESOURCE FOR ALL CUSTOMER SERVICE AND CARE MANAGEMENT REQUESTS



ENROLLMENT GUIDELINES

Welcome to the 2024 Benefits Guide for Porter County Government . This Guide provides a quick overview of the benefits program and helps to remove confusion that sometimes surrounds Employee benefits. The benefits program was structured to provide comprehensive coverage for you and your family. Benefit programs provide a financial safety net in the event of unexpected and potentially catastrophic events.

ELIGIBILITY

You are eligible to enroll in the medical benefits program if you are a full-time employee working 30 or more hours per week. Benefits for newly hired employees will take effect the first day of the month following 30 days of qualified employment. For all other programs, eligible employees must be scheduled to work, and regularly work, 30 hours per week.

Your legally recognized spouse and your married or unmarried dependent children are eligible for medical coverage if less than 26 years of age. Your unmarried dependent children are eligible for dental and/or vision benefits if less than 26 years of age. Disabled unmarried children over age 26 may be eligible to continue benefits after approval of necessary applications.

For Life, Supplemental Life and Disability coverages; Actively at Work Provisions apply.

OPEN ENROLLMENT

Open enrollment for health, dental and vision is once a year and benefit elections will take effect January 1st. Participants may add or drop coverage or make changes to their coverage at this time. Late entrants (employees or dependents who apply for coverage more than 30 days after the date of individual eligibility) are also provided an opportunity to enroll for coverage during the plan's open enrollment. The elections you make stay in effect the entire plan year, unless a qualifying life event occurs.

QUALIFYING LIFE EVENTS

Generally, you can only change your benefit elections during the annual Open Enrollment period. However, you may make changes during the plan year if you have a qualifying event.

Qualifying events include:

- Marriage
- Divorce
- Birth
- Adoption
- Death
- Loss of Coverage

Under the medical plan, Open Enrollment under your spouse's group plan will also be considered a qualifying event.

When you have a qualifying event, you have 30 days to complete and return a new enrollment/change form for health, dental, and/or vision coverage. You may be asked to provide proof of the change and/or proof of eligibility. (You have 60 days to complete and return a new enrollment/change form after coverage under Medicaid or CHIP terminates.)

BENEFIT CONTACTS

PRIMARY POINT OF CONTACT

Apta Health Care Coordinators powered by Quantum	Personal Healthcare Advocacy Team	877-610-8817 https://portercounty.myaptahealth.com

OTHER CONTACTS

Optum Rx	Prescription Benefit Manager	(800) 356-3477 www.umr.com
MetLife	Dental Group #05394320	(800) 275-4638 www.metlife.com/mybenefits
MetLife	Vision Group #05394320	(855) 638-3931 www.metlife.com/mybenefits
First Fidelity Bank	Health Savings Account (H.S.A.) Nick Badger	(402) 212-2567 https://americanfidelity.com/info/hsa/
Equitable	Basic Life, Voluntary Life & AD&D Basic Life Group Voluntary Life Group	(866) 274-9887 www.equitable.com ebcustomerservice@equitable.com
Franciscan Clinic	Nearsite Clinic Provider – Services Available at NO COST	(833) 278-3478 https://www.franciscanretailservices.org/healtheaccess/
American Fidelity	Supplemental Policies	(800) 662-1113 www.americanfidelity.com
Porter County Government	Porter County Government HR Rhonda Young	(219) 510-6075
General Insurance Service Employee Benefits Insurance Broker	Shiloh Carlock Client Service Representative	(219) 510-6220 scarlock@genins.com

GLOSSARY OF TERMS

The following terms will help you better understand your benefits.

Co-pay: A Copay is the portion of the Covered Expense that is your responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible.

Deductible: A Deductible is the total amount of eligible expenses as shown in the Medical Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan.

Coinsurance: Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay.

Out-of-Pocket Maximum (OOPM): An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

PPO (Preferred Provider Organization): This type of plan utilizes network and non-network benefits.

In-Network: The Plan offers a broad network of providers and provides the highest level of benefits when Covered Persons utilize "in-network" providers. These networks will be indicated on your Plan
identification card.

Out-of-Network: Any non-contracted providers. The services from these providers are subject to balance billing, meaning members can be billed for the difference between the insurance carrier's fee schedule and the billed charges.

MEDICAL BENEFITS

Porter County Government offers medical benefits through UMR. This medical plan balances affordability with the freedom to go outside the network. You may choose a participating or a non-participating provider. Participating providers have agreed to provide services at a discounted fee. For out-of-network care, you are responsible for charges above the out-of-network allowance for services, in addition to the deductible and coinsurance. To find a participating provider, visit www.umr.com.

BENEFIT	HDHP PLAN	
	IN-NETWORK	OUT-OF-NETWORK
Deductible	$3,200/single $4,000/family	$5,600/single $7,600/family
Out-of-Pocket Max (Includes deductible and copays)	$5,000/single $10,000/family	$5,000/single $10,000/family
Preventive Care	0% (Deductible Waived)	50% After Deductible
Office Visit (PCP)	0% After Deductible	50% After Deductible
Teladoc (Telemedicine)	0% After Deductible	N/A
Specialist Office Visit with Referral	0% After Deductible	50% After Deductible
Specialist Office Visit without Referral	0% After Deductible	50% After Deductible
Chiropractic Services	0% After Deductible	50% After Deductible
Diagnostic Lab/X-ray	0% After Deductible	50% After Deductible
Imaging (CT/PET scans: MRI's)	0% After Deductible	50% After Deductible
Inpatient Hospital	0% After Deductible	50% After Deductible
Outpatient Hospital	0% After Deductible	50% After Deductible
Maternity Prenatal Delivery and All Inpatient Services	 0% (Deductible Waived) 0% After Deductible	 50% After Deductible 50% After Deductible

Family deductible and out-of-pocket amounts are embedded. This means that an individual would not pay more than the individual deductible/out-of-pocket amounts.

MEDICAL BENEFITS (CONTINUED)

BENEFIT	HDHP PLAN	
	IN-NETWORK	OUT-OF-NETWORK
Mental Health/Substance Abuse Office	0% After Deductible	50% After Deductible
Mental Health/Substance Abuse Inpatient/Outpatient	0% After Deductible	50% After Deductible
Emergency Room	0% After Deductible	
Emergency Transport/Ambulance	0% After Deductible	
Urgent Care	0% after Deductible	50% After Deductible
Prescriptions – through Optum RX Single Family	Maximum Out of Pocket (Combined with Medical) $3,800 $5,800	
Retail – 30-day supply Generic Preferred Non-Preferred Specialty	 0% After Deductible 20% After Deductible 45% After Deductible 20% up to $1,000 After Deductible	 Not covered Not covered Not covered Not Covered
Mail Order – 90-day supply Generic Preferred Non-Preferred Specialty	 0% After Deductible 20% After Deductible 45% After Deductible N/A	 Not covered Not covered Not covered N/A

What you pay and what the plan pays
The above Summary of Benefits shows how much you pay for care, and how much the plan pays. It's a brief listing of what is included in your benefits plan. For more detailed information, see your summary plan description.

Pre-Certification Requirement: A $500 penalty will apply for failure to obtain pre-certification.	• Inpatient Hospitalizations • Skilled Nursing • Facility Admissions • Home Health Care & Services • Oncology Care & Services • MRI's, MRA's & PET Scans • Hospice Care • Outpatient Surgeries (including Colonoscopies) • DME over $1500 • Dialysis • Transplants - Organ & Bone Marrow • Genetic Testing (optional)

REFERRAL PROCESS FOR A SPECIALIST

COORDINATE YOUR CARE THROUGH YOUR PRIMARY CARE PHYSICIAN (PCP)

- Obtain a referral from your PCP before seeing a specialist to save money on member out-of-pocket costs and get alerts for not fully covered benefits
- Helps avoid visits to the wrong specialist
- Helps avoid referrals to an out-of-network specialist
- Get in to see specialist faster
- All referrals obtained are valid for 12 months.
- The PCP must provide the referral to the Care Coordinators.

PRE-CERTIFICATION

Before you receive certain medical services or procedures, your health plan requires a doctor to confirm that these requested services are considered medically necessary under your plan. This verification process is called "pre-certification." Even if some services or therapies are performed in your doctor's office, you may still need a pre-certification. Pre-certification requests must be submitted by your physician directly to the Apta Care Coordinators.

SERVICES REQUIRING PRE-CERTIFICATION			
Inpatient Hospitalizations & Skilled Nursing Facility Admissions	Home Health Care and Services	Oncology Care & Services (chemotherapy, radiation therapy, etc.)	MRI's, MRA's and PET Scans
Hospice Care	Dialysis	Transplants - Organ and Bone Marrow	Durable Medical Equipment (DME) purchases over $1500 and all rentals
Out-Patient Surgeries (includes Colonoscopies)	Genetic Testing		
• A $500 penalty will be applied for all services rendered that do not have pre-certification completed.			

WHAT IS TELEMEDICINE & TELEHEALTH?

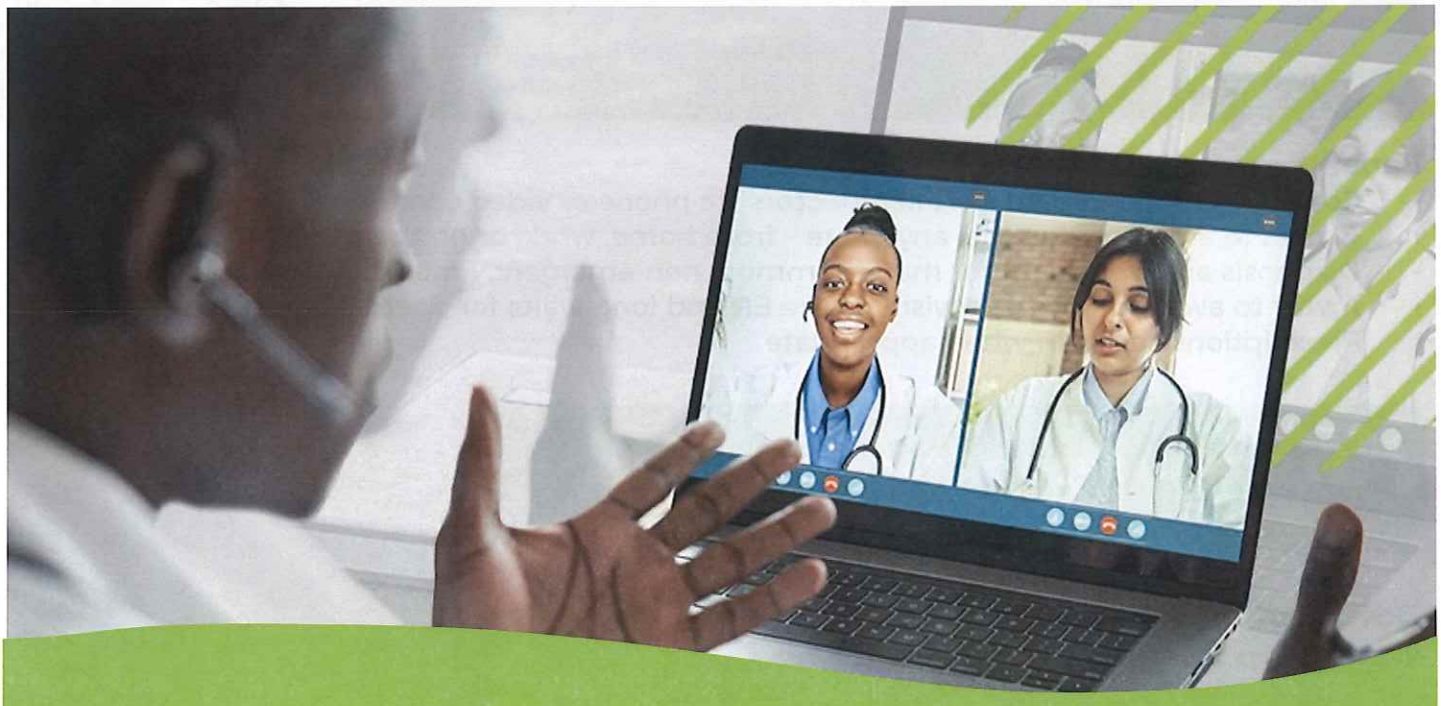
With the onset of Covid-19, telehealth has become an increasingly popular way for individuals to receive medical treatment and diagnosis without visiting a physical, clinical location such as a doctor's office or hospital.

Telemedicine and telehealth are sometimes used interchangeably to describe both clinical and non-clinical interactions with health professionals through technology. While telemedicine focuses on remote clinical assistance, telehealth also includes educational and non-clinical remote interactions through the use of various technologies such as webcams, apps, and mobile devices.

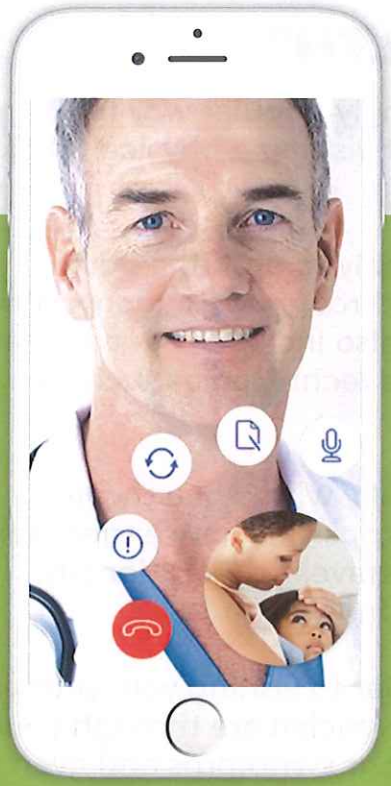
Telemedicine and telehealth provide options for meeting virtually with a healthcare provider when you are not feeling well. Using technology and apps, it is now easier than ever to meet with a physician from your home, office, or while traveling. Additionally, physicians are available outside of normal business hours and on weekends.

Meeting with a doctor through an app like Teladoc is very similar to visiting your primary care physician in an office, except your interactions with the physician are through your mobile device. The doctor can give you a diagnosis based on your symptoms and even provide a prescription that can be picked up from your local pharmacy.

You can contact a doctor at any time using this benefit and there is no need to contact your care coordinator prior to using this service. We recommend you download the app to your phone now so that you can use this option when needed. More information is available on the next page.



DID YOU KNOW... TELEHEALTH IS A NEW, CONVENIENT WAY TO GET MEDICAL CARE BY VIRTUALLY VISITING YOUR DOCTOR



TELADOC.

Talk to a anytime

MEET WITH A DOCTOR WITHOUT LEAVING YOUR HOME THROUGH YOUR MOBILE DEVICE!

Teladoc is one of the nation's most established providers of telehealth services. Our national network of U.S. board-certified doctors is standing by to provide quality healthcare for you and your family, 24/7.

From the information you provide, Teladoc can diagnose many illnesses and injuries, order prescriptions, and know immediately if you need to be referred to in-person emergency care.

Teladoc medical and psychiatrist visits are as follows:

Medical Visits:
- PPO Plan - $49 per visit, subject to deductible/coinsurance
- HDHP Plan - $49 per visit, subject to deductible/coinsurance

Psychiatrist Visits:
- PPO Plan - - $220 for initial evaluation, $100 for ongoing visits, subject to deductible and coinsurance
- HDHP Plan - $220 for initial evaluation, $100 for ongoing visits, subject to deductible and coinsurance

Licensed Therapist Visits:
- PPO Plan - $90 per visit, subject to deductible/coinsurance
  HDHP Plan - $90 per visit, subject to deductible/coinsurance

Benefits:
- Consults with U.S. Board-Certified doctors via phone or video conference 24/7
- Access to a doctor anytime, anywhere – from home, work, or on the road
- Diagnosis and treatment for many common, non-emergency medical conditions
- A way to avoid unnecessary visits to the ER and long waits for doctor appointments
- Prescriptions called-in when appropriate

BE PREPARED FOR THE UNEXPECTED!

Download the App on Google Play for Android, or via the App Store for iPhone/iPad

Available on the App Store

ANDROID APP ON Google Play

Teladoc.com/mobile or visit your app store.

1-800-Teladoc

APTA CASH CAN HELP SAVE YOU MONEY!

DO YOU NEED SURGERY OR AN EXPENSIVE DIAGNOSTIC TEST?

WHAT IS APTA CASH?
It's a healthcare concierge service that helps employees lower their out-of-pocket costs by choosing high-quality providers who offer affordable cash prices.

WHEN SHOULD I CONTACT APTA CASH?
Whenever one of your doctors or medical providers recommend a major diagnostic test or surgery that can be planned in advance, contact Apta Cash first at **855-378-0770.**

WHY SHOULD I CONTACT APTA CASH?
Your health plan has partnered with Apta Cash to help you and your employer save money. Your plan deductible and coinsurance will be waived when you use Apta Cash. If you are enrolled in a HDHP Plan, the minimum deductible may apply.

HOW DOES THE PROGRAM WORK?
When you contact Apta Cash, your coordinator will ask you questions to understand the procedure you need and help you choose a high-value provider. Next, they will attempt to negotiate a cash price for your procedure that is less than your medical plan's typical cost. When you, the provider, and the plan agree to the cash rate, Apta Cash will walk you through the steps to get the procedure scheduled, make sure any required pre-certification is completed, and prepare to pay the full cash price when you receive care.

apta cash

Powered by medEcash

CALL TODAY 855-378-0770

FOLLOWING THESE 7 STEPS WILL HELP YOU SAVE MONEY

1. When you have pain
2. Schedule an appointment with your doctor
3. Receive the diagnosis from doctor
4. When doctor recommends surgery
5. Call your Apta Cash Coordinator
6. We identify providers and negotiate a cash price
7. You save $$$!

OPTIONS FOR THOSE NEEDING SPECIFIC SURGERIES

APTA CASH SURGICAL CENTERS OF EXCELLENCE AND SECOND OPINIONS

This smart care program is a cost-saving solution designed for individuals that have been advised to have spine surgery, heart or valve surgery or organ transplants.

Members are provided access to centers of medical excellence, ensuring that the original diagnosis is correct, and the current treatment plan is appropriate, both of which are highly cost-effective.

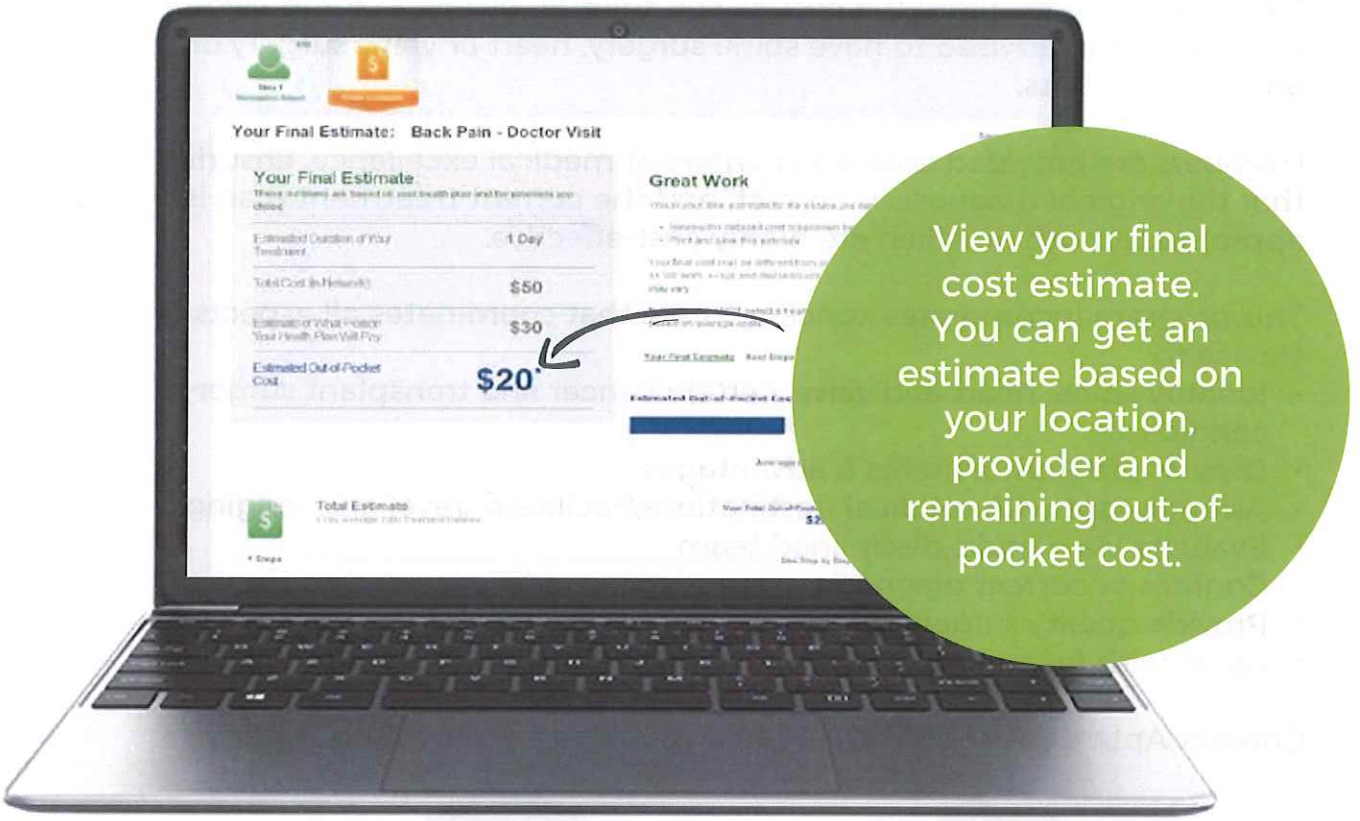
This program incorporates concierge care that coordinates all aspects of service to:

- Identify spine, heart and valve, certain cancer and transplant surgery candidates
- Discuss program benefits & advantages
- Arrange care with medical destinations/Facilitate travel and lodging
- Evaluate via a multi-disciplined team
- Confirm or correct diagnosis
- Provide quality surgery or alternative treatment
- Assist with follow-up care and monitor results

Contact Apta Cash at 855-378-0770 if you have an upcoming surgery.

myHealthcare Cost Estimator (myHCE)

myHCE allows you to research treatment options and learn about the recommended care and estimated costs employed with your selected treatment option. You can even access quality and efficiency measurements for participating providers.



MEDICAL COSTS CAN VARY A LOT FROM ONE DOCTOR TO ANOTHER – SO IT PAYS TO SHOP AROUND.

Your Care Coordinator can help you with the health cost estimator and can:

- Search for the type of service you need
- Compare the true costs of care using real data from real doctors
- Check which providers earned our UnitedHealth Premium rating for cost and quality
- See the total charge for your treatment, and know what to expect from beginning to end

Its easy to get started. Just look for the Health cost estimator tile on your personal home page

PREMIUMS

Employee Contributions
Effective January 1, 2024

HDHP MEDICAL PLAN – INCLUDES DENTAL	Premium Paid by Employee
	Monthly
Single	$25
Employee + Spouse	$50
Employee + Child(ren)	$75
Family	$125

VISION PLAN - METLIFE	Premium Paid by Employee
	Monthly
Single	$7.00
Employee + Spouse	$15.09
Employee + Child(ren)	$12.17
Family	$20.26

HEALTH SAVINGS ACCOUNT (HSA)

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA.)?
A Health Savings Account (HSA) is an account that can be funded by you with pre-tax dollars. The HSA helps pay for eligible medical expenses not covered by an insurance plan, including the deductible, coinsurance, and in some cases, health insurance premiums.

WHO IS ELIGIBLE FOR A HEALTH SAVINGS ACCOUNT?
Anyone who satisfies all of the following:

- Covered by a Qualified High Deductible Health Plan (QHDHP);
- Employee cannot be covered under another medical plan;
- Not enrolled in Medicare A or Medicare B benefits; and,
- Not eligible to be claimed on another person's tax return.

WHAT IS A DEDUCTIBLE?
It is a set dollar amount, determined by your plan that you must pay out-of-pocket or from your HSA account, before insurance coverage for medical expenses can begin.

WHAT IS THE DIFFERENCE BETWEEN AN HSA AND FLEXIBLE SPENDING ACCOUNT (FSA)?

- An HSA can roll-over unused funds from year to year, indefinitely.
- FSA contribution limits are lower than for HSAs. In addition, not all FSAs have a roll-over feature, and those that do can only roll-over a limited amount.

WHEN DO I USE MY HSA?
After visiting a physician, facility, or pharmacy, request that they submit your claim to your health plan for payment. You should make sure that your provider has your most up-to-date insurance information. Once the claim has been processed, any out-of-pocket expenses will be billed. At this time, you may choose the following options:

- Use your HSA debit card or, if included, HSA check (checks can be purchased separately or through First Fidelity Bank to pay for any out-of-pocket expenses.
- You can choose to save your HSA dollars for future medical expenses.

You should always ask that your claim be submitted to the health plan before you seek reimbursement from your HSA. This procedure will ensure that provider discounts are applied. Also, remember to keep all medical receipts and Explanation of Benefits (EOBs) to support your personal tax record. You should keep these records for at least four years.

HOW MUCH CAN BE CONTRIBUTED TO AN HSA?
As noted by federal law, the Annual Contribution limits are:

COVERAGE LEVEL	2024 Employer Contribution	2024 Employee Contribution Limit	2024 MAXIMUM CONTRIBUTION
Individual	$800	$3,350	$4,150
Two Party	$1,200	$7,150	$8,350
Family	$1,200	$7,150	$8,350
Individuals aged 55 or older may be eligible to make a catch-up contribution of $1,000			

Employer contributions are deposited into HSA Account quarterly.

HEALTH SAVINGS ACCOUNT (CONTINUED)

WHAT IF I AM A NEW HIRE OR HAVE A SPECIAL ENROLLMENT AND ENROLL IN AN HSA IN THE MIDDLE OF A YEAR?

If you enroll in an HSA and corresponding HDHP at any time other than the start of the calendar year, so long as you enroll by December 1, you may still contribute the maximum amount allowed for the calendar year. (See the chart on the previous page.) However, the IRS requires you to participate in the HDHP during a subsequent testing period (generally through the end of the following year). Failure to do so will result in adverse tax consequences..

WHY SHOULD I ELECT AN HSA?

1. Cost Savings
   - Tax benefits:
   - HSA contributions are excluded from federal income tax.
   - Interest earnings may be tax free.
   - Withdrawals for eligible expenses are exempt from federal income tax.
   - Unused money is held in interest-bearing savings or investment accounts from year to year.
2. Long Term Financial Benefits
   - Save for future medical expenses, including retiree medical
   - Funds roll over year to year
   - This is your account – you take it with you. If you leave your employer, you can do the following:
     - Leave your funds in the current HSA account;
     - Transfer your funds to an HSA with your new employer; or
     - Transfer your funds to another qualifying account within 60 days.
3. Choice
   - You control and manage your health care expenses.
   - You choose when to use your HSA dollars to pay your health care expenses.
   - You choose when to save your HSA dollars and pay health care expenses out-of-pocket.

FREQUENTLY ASKED QUESTIONS

Can I use my HSA dollars for non-eligible expenses?
Money withdrawn from an HSA account to reimburse non-eligible expenses is taxable income to the accountholder and is subject to a tax penalty. If the accountholder is over age 65 OR disabled, the distribution amount, if for a non-eligible expense, IS still considered taxable income; however, the tax penalty IS waived.

When can I start using my HSA dollars?
You can use your HSA dollars immediately following your HSA account activation, once contributions have been made.

Can my HSA dollars be used for retirement health care costs?
Yes, for medical expenses eligible for reimbursement, and Medicare and other health coverage premiums after age 65.

Can I use the money in my account to pay for my dependents' medical expenses?
Yes, you can use the money in the account to pay for medical expenses of yourself, your spouse, or your dependents.

POCO Wellness Connection

Choose Health for Life 2024!

BRONZE	SILVER	GOLD	PLATINUM
250 POINTS	500 POINTS	750 POINTS	1000 POINTS

Participate in the POCO Wellness Connection and earn points to qualify for the award options. **Your choice!**

Employees enrolled in the Porter County High Deductible HSA Plan can earn points to receive HSA contributions.

Bronze/250 Points: **$125 HSA Contribution**
Silver/500 Points: **Additional $125 HSA Contribution**
Gold/750 Points: **Additional $125 HSA Contribution**
Platinum/1000 Points: **Additional $125 HSA Contribution**

OR

Any Employee may choose to receive Gift Cards as an award. **Subject to income tax.*

Bronze/250 Points: **$125 Gift Card**
Silver/500 Points: **Additional $125 Gift Card**
Gold/750 Points: **Additional $125 Gift Card**
Platinum/1000 Points: **Additional $125 Gift Card**

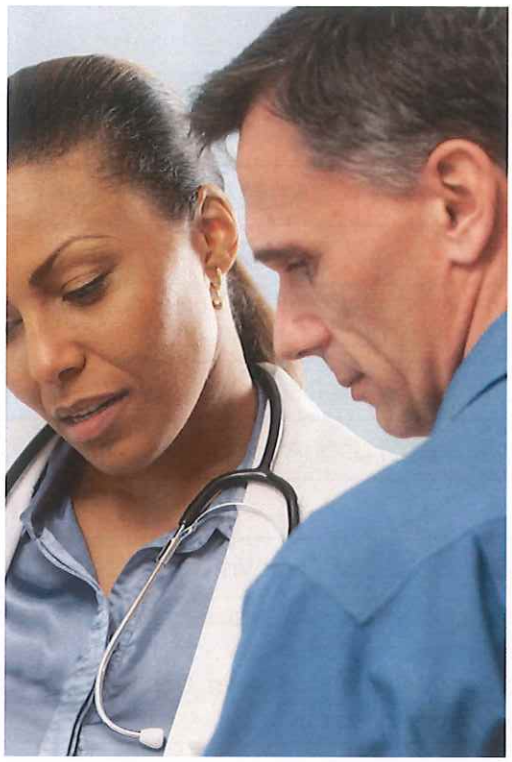
Earn only 500 more points to reach Diamond Level and earn one day PTO!

Diamond: 1500 Points!

Health Screening & Health Risk Assessment	
Activity	**Points Earned for Completion of Activity**
Complete Annual Wellness Screening: Onsite or HEALTHeACCESS Clinic	100 Points
Complete Health Risk Assessment	50 Points
Non-tobacco User (Affidavit optional)	50 Points
Care Compliance	
HEALTHeACCESS Clinic Visit (medical plan only)	25 Points Each (Max: 200)
Preventive Exams: (Annual Exam, Mammogram, Prostate Exam, Colorectal Screen, Bone Density Screen, Skin Cancer Screen, Dental Exam, Vision Exam, Well Woman Exam)	25 Points Each (Max: 200)
Vaccinations: Flu	25 Points
Condition Care Classes	25 Points Each
Get Active (Pedometer Challenge)	
Sync a fitness device and record 250,000 steps	100 Points Each (No Max)
12 Workouts per month	25 Points
Lifestyle/Enrichment Activities	
Live & On Demand Wellness Classes	10 Points Each (Max: 100)
Standard Challenges: Color Challenge, H2O Challenge, Well-Rested Challenge, Gratitude Challenge	50 Points Each
Featured Challenges: Walk Route 66, BINGO, Catchlife, All About Me	100 Points Each
Well-Being Modules	
Animo Think Well (Digital CBT)	100 Points
Financial Wellness (Per Module)	20 Points
Community	
Walking Tours: Visit Indiana Landmarks	25 Points
Healthy Recipe and Tastings	25 Points
Participate in a Charity Community walk/run	25 Points
Participate in Sponsored Wellness Event: Variety of events including Sports Teams, Library Events, etc.	25 Points
Porter County Health Fair-per booth	5 Points (Max 25 Points)

Visit www.healtheaccesscws.com to access your portal. Need help logging in to the POCO Wellness portal or want to learn how to earn points? Contact support@workingwellcws.com or call support at 260-434-0909.

your HealtheACCESS® EMPLOYEE CLINIC PROGRAM



Need to schedule an appointment or better understand your healthcare situation?

CALL YOUR HEALTHCARE NAVIGATOR

(833) 278-3478

SCAN QR OR VISIT HealthEAccess.org

YOUR HEALTHCARE NAVIGATOR CAN HELP WITH:

- Scheduling appointments
- One-to-one guidance
- Identifying resources for you to use
- Needing to express concerns to someone

Franciscan ALLIANCE

OCC1104262316N

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BRAND	GENERIC	STRENGTH	QTY	FORM
Zovirax	acyclovir	200MG	30	CAPS
VentolinHFA	albuterol sulfate	0	18GM	AERS
Ventolin HFA	albuterol sulfate	0	8GM	AERS
Proventil	albuterol sulfate	0.08%	525x3mL	UD
Zyloprim	allopurinol	300MG	90	TABS
Norvasc	amlodipine besylate	10MG	90	TABS
Norvasc	amlodipine besylate	5MG	90	TABS
Amoxil	amoxicillin	250/5ML	150	SUSR
Amoxil	amoxicillin	250MG	30	CAPS
Amoxil	amoxicillin	400/5ML	100	SUSR
Amoxil	amoxicillin	500MG	40	CAPS
Augmentin	amoxicillin/clavulanate potassium	200/5ML	100	SUSR
Augmentin	amoxicillin/clavulanate potassium	875MG	20	TABS
ecotrin	aspirin	81MG EC	120	TBEC
Ecotrin	aspirin/enteric coated	325MG E	90	TBEC
Tenormin	atenolol	100MG	90	TABS
Tenormin	atenolol	25MG	90	TABS
Tenormin	atenolol	50MG	90	TABS
Lipitor	atorvastatin calcium	20MG	90	TABS
Lipitor	atorvastatin calcium	40MG	90	TABS
Lipitor	atorvastatin calcium	80MG	90	TABS
Zithromax	azithromycin	200/5ML	30	SUSR
Zithromax	azithromycin	250MG	6	TABS
Bacitracin	bacitracin zinc	500/GM	14.17	OINT
Polysporin	bacitracin zinc/polymyxin B sulfate	OP	3.5	OINT
Lioresal	baclofen	10MG	90	TABS
	benazepril HCl	20MG	90	TABS
Tessalon Pearls	benzonatate	100MG 3	0	CAPS
Valisone	betamethasone valerate	0.001	15	CREA
Wellbutrin SR	bupropion hcl SR	150MG S	30	TB12
Wellbutrin XL	bupropion hcl XL	300MG	30	TABS
Buspar	buspirone HCl	10MG	90	TABS
Debrox	carbamide peroxide/(ear drops)	6.5% OT	15	SOLN
Keflex	cephalexin	500MG	30	CAPS
Zyrtec	cetirizine/hydrochloride	10MG	90	TABS
Cipro	Ciprofloxacin	500MG	30	TABS
Celexa	citalopram HBr	20MG	90	TABS
Celexa	citalopram HBr	40MG	90	TABS
	clindamycin	300MG	30	TABS
Catapres	clonidine HCl	0.2MG	90	TABS
Plavix	clopidogrel bisulfate	75MG	90	TABS
Flexeril	cyclobenzaprine HCL	10MG	60	TABS
Cardizem	diltiazem HCl	60MG	30	TABS
Cardizem CD	diltiazem HCl/(once-a-day dosage)	180MG E	30	CP24
Benadryl	diphenhydramine HCl	25MG	20	CAPS
	doxycycline	100MG	20	TABS

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BRAND	GENERIC	STRENGTH	QTY	FORM
Vasotec	enalapril maleate	10MG	90	TABS
Lexapro	escitalopram oxalate	10MG	90	TABS
	fexofenadine HCl	180MG	90	TABS
	fish oil	1000MG	100	CAPS
Diflucan	fluconazole	150MG	1	TABS
Prozac	fluoxetine	10MG	90	CAPS
Prozac	fluoxetine	20MG	90	CAPS
Prozac	fluoxetine	40MG	90	CAPS
Flonase	fluticasone propionate	50MCG	16	SUSP
Lasix	furosemide	20MG	90	TABS
Lasix	furosemide	40MG	90	TABS
Neurontin	gabapentin	300MG	90	CAPS
Lopid	gemfibrozil	600MG	90	TABS
Amaryl	glimepiride	2MG	90	TABS
	glimepiride	4MG	90	TABS
Glucotrol	glipizide	10MG	30	TABS
Glucotrol	glipizide	5MG	30	TABS
Diabeta	glyburide	2.5MG	30	TABS
Diabeta	glyburide	5MG	90	TABS
Microzide	hydrochlorothiazide	12.5MG	90	CAPS
HydroDiuril	hydrochlorothiazide/(HCTZ)	25MG	90	TABS
	hydrocortisone	0.01	28.4	CREA
Hytone	hydrocortisone	0.025	30	CREA
Advil	ibuprofen	200MG	30	TABS
Motrin	ibuprofen	800MG	90	TABS
Indocin	indomethacin	50MG	90	CAPS
Prevacid	lansoprazole	30MG DR	30	CPDR
Synthroid	levothyroxine sodium	100MCG	90	TABS
Synthroid	levothyroxine sodium	112MCG	90	TABS
Synthroid	levothyroxine sodium	125MCG	90	TABS
Synthroid	levothyroxine sodium	150MCG	90	TABS
Synthroid	levothyroxine sodium	50MCG	90	TABS
Synthroid	levothyroxine sodium	75MCG	90	TABS
Synthroid	levothyroxine sodium	88MCG	90	TABS
Zestril or Prinivil	lisinopril	10MG	90	TABS
Zestril or Prinivil	lisinopril	20MG	90	TABS
Zestril	lisinopril	40MG	90	TABS
	lisinopril-hydrochlorothiazide	10-12.5	90	TABS
Claritin	loratadine	10MG	90	TABS
Cozaar	losartan potassium	100MG	90	TABS
Cozaar	losartan potassium	25MG	90	TABS
Cozaar	losartan potassium	50MG	90	TABS
Hyzaar	losartan potassium/hydrochlorothiazide	50-12.5	90	TABS
Mevacor	lovastatin	20MG	90	TABS
Mevacor	lovastatin	40MG	90	TABS

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EMPLOYER CLINIC PROGRAM

BRAND	GENERIC	STRENGTH	QTY	FORM
	macrobid	100MG	10	TABS
Antivert	meclizine	25MG	20	TABS
Mobic	meloxicam	15MG	30	TABS
	meloxicam	7.5MG	90	TABS
Glucophage XR	metformin ER	500MG E	90	TB24
Glucophage	metformin HCl	1000MG	90	TABS
Glucophage	metformin HCl	500MG	90	TABS
Medrol Dosepak	methylprednisolone	4MG	21	TBPK
Lopressor	metoprolol tartrate	100MG	90	TABS
Lopressor	metoprolol tartrate	25MG	90	TABS
Lopressor	metoprolol tartrate	50MG	90	TABS
	metronidazole	500mg	14	TABS
	miconazole nitrate	0.02	30	CREA
Singulair	montelukast sodium	10MG	90	TABS
Naprosyn	naproxen	500MG	30	TABS
	nitroglycerin	0.4MG	25	SUBL
Prilosec	omeprazole	20MG	90	CPDR
	omeprazole	40MG	60	CPDR
Zofran	ondansetron	4MG	10	TABS
	ondansetron ODT	4MG	10	TABS
Paxil	paroxetine HCl	20MG	90	TABS
	paroxetine HCl	40MG	90	TABS
Penb-VK	penicillin potassium	500MG	30	TABS
Klor-Con M20	potassium chloride	20MEQ E	90	TBCR
K-tab	potassium chloride/(750mg)	10MEQ E	90	TBCR
Pravachol	pravastatin sodium	20MG	90	TABS
Pravachol	pravastatin sodium	40MG	90	TABS
Prednisone	prednisone	20MG	30	TABS
Prednisone	prednisone	5MG	21	TABS
Phenergan	promethazine	25MG	10	TABS
Inderal	propranolol	10MG	100	TABS
Inderal	propranolol	40MG	90	TABS
Accupril	quinapril	20MG	30	TABS
Accupril	quinapril	40MG	30	TABS
Zoloft	sertraline HCl	100MG	90	TABS
Zoloft	sertraline HCl	50MG	90	TABS
Zocor	simvastatin	20MG	90	TABS
Zocor	simvastatin	40MG	90	TABS
Bactrim DS	sulfamethoxazole/trimethoprim	800-160	20	TABS
Flomax	tamsulosin HCl	0.4MG	30	CAPS
Tobrex	tobramycin	0.3% OP	5	SOLN
Desyrel	trazodone	50MG	90	TABS
Neosporin	triple antibiotic ointment	0	30	OINT
	valacyclovir	500MG	30	TABS
Effexor XR	venlafaxine HCl	75MG ER	90	CP24

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03/2021 OCCH022521NI

LOCATIONS

CARMEL
10767 Illinois St. Suite 1300
Carmel, IN 46032
(317) 528-2777

MON- FRI 8AM-5PM

CRAWFORDSVILLE
1640 Crawfordsville Square Dr
Crawfordsville, IN 47933
(765) 362-6374

MON-FRI 8AM-5PM

CROWN POINT
12800 Mississippi Pkwy, Suite A204
Crown Point, IN 46307
(219) 662-5500

MON-FRI 8AM-6PM
SAT 8AM-4PM

HOBART
101 W61st Ave.
Hobart, IN 46343
(219) 945-9530

MON-FRI 8AM-6PM

LAFAYETTE
3218 Daughtery, Suite 140
Lafayette, IN 47909
(765) 502-4190

MON-FRI 7AM- 7PM

MICHIGAN CITY
4111 S Franklin St.
Michigan City, IN 46360
(219) 879-5400

MON-FRI 8AM-6PM
SAT 8AM-4PM

MOORESVILLE
1215 Hadley Rd., Suite 205
(317) 834-5220

MON-FRI 8AM-5PM

Munster
7905 Calumet Ave.
Munster, IN 46321
(219) 836-4690

MON-FRI 8AM- 6PM
SAT 8AM-4PM

PORTAGE
3283 Willowcreek Rd.
Portage, IN 46368
(219) 764-8439

MON-FRI 8AM-6PM
SAT 8AM-4PM

RENSSELAER
919 E. Grace St.
Rensselaer, IN 47978
(219) 866-0411

MON-FRI 8AM-6PM
SAT 8AM-4PM

STONES CROSSING
1703 WStones Crossing Rd. Suite 100 Greenwood, IN 46143 (317) 528-2141

MON-FRI 8AM-8PM
SAT/SUN 10AM-6PM

VALPARAISO
2307 Laporte Ave., Suite 8
Valparaiso, IN 46383
(219) 464-7073

MON-FRI 8AM-6PM
SAT 8AM-4PM

Continuing Christ's Ministry in our Franciscan Tradition

Franciscan HEALTHeACCESS

HEALTHeACCESS
EMPLOYER CLINIC PROGRAM

Frequently Asked Questions

Who is eligible for the program?
The program is available for the benefit of all enrolled employees and dependents.

What will the program cost me?
There is no cost to you for this program.

Do I have to make an appointment?
Appointments are not required but recommended for your convenience.

What types of visits are covered?
Standard primary care, wellness, and urgent care visits are all covered, with some specific limitations. Work-related injuries are not covered.

Are all medications covered?
Many common prescription medications are included. However, there may be additional prescription costs outside of this program, dependent on your need. Please see medication list.

Is blood work covered?
There are some standard lab and instant tests that are included in the program. Including but not limited to: complete blood count, lipid panel, thyroid testing, hemoglobin A1C, rapid strep, flu, mono, pap smear, pregnancy and STD testing. There will be an additional cost for any non-covered lab work ordered.

What type of identification will I need to present at the clinic?
A valid driver's license or photo ID. Insurance card in case additional services are needed. Minors must be accompanied by a legal guardian.

Where do I go if the clinic is closed?
If the clinic is closed, we recommend using the Franciscan Telemedicine program or the closest emergency room for emergencies. These services will require the use of your insurance.

What clinic can I go to?
See the other side of this flyer for all HEALTHeACCESS locations and details.

Franciscan
HEALTHeACCESS

Scan Me!

MetLife

Dental

Metropolitan Life Insurance Company

Plan Design for: Porter County Government
Original Plan Effective Date: January 1, 2022

Network: PDP Plus

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

Coverage Type:	**In-Network[1]** % of Negotiated Fee[2]	**Out-of-Network[1]** % of R&C Fee[4]
Type A - Preventive	80%	80%
Type B - Basic Restorative	80%	80%
Type C - Major Restorative	80%	80%
Type D - Orthodontia	50%	50%
Deductible[3]		
Individual	$50	$50
Family	$100	$100
Annual Maximum Benefit:		
Per Individual	$1200	$1200
Orthodontia Lifetime Maximum - Ortho applies to Child Only	Child to age 19	
	$1000 per Person	$1000 per Person
Dependent Age:	Eligible for benefits until the day that he or she turns 26.	

1. "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
2. Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
3. Applies to Type B and C services only.
4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   - the dentist's actual charge (the 'Actual Charge'),
   - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
   - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.

Understanding Your Dental Benefits Plan

The Preferred Dentist Program is designed to provide the dental coverage you need with the features you want. Like the freedom to visit the dentist of your choice – in or out of the network. .

If you receive in-network services, you will be responsible for any applicable deductibles, cost sharing, negotiated charges after benefit maximums are met, and costs for non-covered services. If you receive out-of-network services, you will be responsible for any applicable deductibles, cost sharing, charges in excess of the benefit maximum, charges in excess of the negotiated fee schedule amount or R&C Fee, and charges for non-covered services.

- Plan benefits for in-network covered services are based on a percentage of the Negotiated fee – the Fee that participating dentists have agreed to accept as payment in full for covered services, subject to any deductibles, copayments, cost sharing and benefit maximums. Negotiated fees are subject to change.
- Plan benefits for out-of-network services are based on a percentage of the Reasonable and Customary (R&C) charge. If you choose a dentist who does not participate in the network, your out-of-pocket expenses may be greater.

Once you're enrolled you may take advantage of online self-service capabilities with MyBenefits.

- Check the status of your claims
- Locate a participating dentist
- Access MetLife's Oral Health Library
- Elect to view your Explanation of Benefits online

To register, just go to
www.metlife.com/mybenefits
and follow the easy registration instructions.

Selected Covered Services and Frequency Limitations*

Type A - Preventive	How Many/How Often:
Oral Examinations	2 in a year
Full Mouth X-rays	1 in 60 months
Bitewing X-rays (Adult/Child)	1 in 12 months
Prophylaxis - Cleanings	2 in a year
Topical Fluoride Applications	2 in a year - Children to age 19

Type B - Basic Restorative	How Many/How Often:
Sealants	1 in a lifetime - Children to age 14
Space Maintainers	No limit - Children up to age 14
Amalgam and Composite Fillings	1 in 24 months.
Repairs	1 in 12 months
Endodontics Root Canal	1 per tooth per lifetime
Periodontal Surgery	1 in 36 months per quadrant
Periodontal Scaling & Root Planing	1 in 24 months per quadrant
Periodontal Maintenance	2 in 1 year, includes 2 cleanings
Oral Surgery (Simple Extractions)	
Oral Surgery (Surgical Extractions)	
Other Oral Surgery	
Emergency Palliative Treatment	

Type C - Major Restorative	How Many/How Often:
Crowns/Inlays/Onlays	1 per tooth in 5 years
Prefabricated Crowns	1 per tooth in 5 years
Bridges	1 in 5 years
Dentures	1 in 5 years
General Anesthesia	
Consultations	1 in 12 months
Implant Services	1 service per tooth in 5 years - 1 repair per 12 months

Type D – Orthodontia

- Dependent children up to age 19. Age limitations may vary by state. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Benefits for the initial placement will not exceed 20% of the Lifetime Maximum Benefit Amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits and procedures performed in connection with the orthodontic treatment, are all subject to the Orthodontia coinsurance level and Lifetime Maximum Benefit Amount as defined in the Plan Summary.
- Orthodontic benefits end at cancellation of coverage

***Alternate Benefits:** Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description/Insurance certificate for complete details. In the event of a conflict with this summary, the terms of your insurance certificate will govern.

MetLife

Vision Plan Summary

Metropolitan Life Insurance Company

In-network benefits

There are no claims for you to file when you go to a participating vision specialist. Simply pay your copay and, if applicable, any amount over your allowance at the time of service.

Frequency

Eye exam

Once every **12** months

- Eye health exam, dilation, prescription and refraction for glasses: Covered in full after a **$10** copay.
- Retinal imaging: Up to a **$39** copay on routine retinal screening when performed by a private practice provider.

Frame

Once every **24** months

- Allowance: **$110** after **$25** eyewear copay.
- Costco, Walmart and Sam's Club: **$60** allowance after **$25** eyewear copay.
  You will receive an additional **20%** savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco, Walmart and Sam's Club.

Standard corrective lenses

Once every **12** months

- Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after **$25** eyewear copay.

Standard lens enhancements[1]

Once every **12** months

- Polycarbonate (child up to age 18) and Ultraviolet (UV) coating: Covered in full after **$25** eyewear copay.
- Progressive Standard, Progressive Premium/Custom, Polycarbonate (adult), Photochromic, Anti-reflective, Scratch-resistant coatings and Tints: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at _____

Contact lenses instead of eye glasses

Once every **12** months

- Contact fitting and evaluation: Covered in full with a maximum copay of $60.
- Elective lenses: **$110** allowance.
- Necessary lenses: Covered in full after eyewear copay.

We're here to help

Find a Vision provider at

_____

Download a claim form at

_____

For general questions go to

_____

or call 1-855-MET-EYE1
(1-855-638-3931)

Out-of-network reimbursement

You pay for services and then submit a claim for reimbursement. The same benefit frequencies for **In-network benefits** apply. Once you enroll, visit _____ for detailed out-of-network benefits information.

- Eye exam: up to **$45**
- Frames: up to **$55**
- Contact lenses:
  - Elective up to **$90**
  - Necessary up to **$210**
- Single vision lenses: up to **$30**
- Lined bifocal lenses: up to **$50**
- Lined trifocal lenses: up to **$65**
- Lenticular lenses: up to **$100**
- Progressive lenses: up to **$50**

With your Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision specialist and receive coverage. Just remember your benefit dollars go further when you stay in network.
- Choose from a large network of ophthalmologists, optometrists and opticians, from private practices to retailers like Costco® Optical, Walmart, Sam's Club and Visionworks.

In-network value added features:

Additional lens enhancements: In addition to standard lens enhancements, enjoy an average 20-25% savings on all other lens enhancements.[1]

Savings on glasses and sunglasses: Get 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.[1]

Laser vision correction:[2]
Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. This offer is only available at MetLife participating locations.

Exclusions and Limitations of Benefits

This plan does not cover the following services, materials and treatments:

Services and Eyewear

- Services and/or materials not specifically included in the Vision Plan Benefits Overview (Schedule of Benefits).
- Any portion of a charge above the Maximum Benefit Allowance or reimbursement indicated in the Schedule of Benefits.
- Any eye examination or corrective eyewear required as a condition of employment.
- Services and supplies received by you or your Dependent before the Vision Insurance starts.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Local, state and/or federal taxes, except where MetLife is required by law to pay.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
- Services and materials obtained while outside the United States, except for emergency vision care.
- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.
- Services: (a) for which the employer of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
- Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Vision Insurance under the Group Policy be paid first. Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government. The term does not include any plan, program, or coverage provided by a government as an employer or Medicare.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses, furnished under this Plan which are lost, stolen, or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Contact lens insurance policies and service agreements.
- Refitting of contact lenses after the initial (90 day) fitting period.
- Contact lens modification, polishing, and cleaning.

Treatments

- Orthoptics or vision training and any associated supplemental testing.
- Medical and surgical treatment of the eye(s).

Medications

- Prescription and non-prescription medication

[1] All lens enhancements are available at participating private practices. Maximum copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. Please contact your local Costco, Walmart and Sam's Club to confirm availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.

[2] Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations.

Important: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

M110D-10/25

MetLife Vision benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Certain claims and network administration services are provided through Vision Service Plan (VSP), Rancho Cordova, CA. VSP is not affiliated with Metropolitan Life Insurance Company or its affiliates.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods, and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.

EQUITABLE

Group name: Porter County Government
Policy number: 017422
Effective date: 01/01/2024

Protection for you and your loved ones

Life insurance benefit summary

The importance of Life insurance

The right life insurance coverage can help protect your loved ones and help provide financial stability when they need it most. They can use the benefit to fund a child's education, pay off a mortgage or pay for everyday expenses.

Watch this quick video to learn more

Did you know?

More than ⅓ of households would feel the financial impact in less than 6 months if the primary wage earner died.[1]

Today, few have the coverage they need. And 48% of households (60 million) have an average life insurance coverage gap of

$200,000

Basic Life/AD&D Benefit plan and features

Class definition: Class 1 – All Active Full Time Employees

Coverage Details	Employee
Life Benefit Amount	$20,000
Life Maximum Benefit	$20,000
Guaranteed Issue Amount	$20,000
Life Age Reduction	
Age 65 but less than 70	65%
Age 70 or over	50%
Any reduction pursuant to this provision will take place on the next Policyholder anniversary date	
Accelerated Death Benefit	80% up to $250,000
Waiver of Premium	Included

Coverage Details	Employee
Conversion	Included
Accidental Death & Dismemberment (AD&D) Benefit Amount	100% of Life Insurance Benefit
AD&D Maximum Benefit	Matches Life Insurance Maximum
AD&D Age Reduction	Matches Life

AD&D Features	Employee
Common Carrier Benefit	Included
Exposure/Disappearance Benefit	Included
Rehabilitation/Physical Therapy Benefit	Included
Seatbelt and Airbag Benefits	Included

Understanding your benefits

Commonly Used Terms

Guarantee Issue Amount	This is the amount of insurance available without having to provide evidence of insurability (also known as proof of good health).
Accelerated Death Benefit	Allows you access to a portion of your Life insurance while you are alive if you have a qualifying condition, such as a terminal illness, cognitive impairment, or the inability to perform two or more activities of daily living without assistance.
Conversion	Allows you convert your group term Life insurance coverage to an individual, whole life policy if your coverage is reduced or ends.

Frequently Asked Questions

When can I enroll for coverage?	You can enroll when you are initially eligible, during any annual enrollment period, or within 31 days of a family status change. Evidence of insurability (also known as proof of good health) may be required. Please see your coverage certificate for details.
Are my spouse and dependent children eligible for coverage?	No, your employer's plan does not provide for coverage on your spouse or children.
Does the coverage decrease as I get older?	Yes, the age reductions are shown in the "Benefit Plan & Features" section. The coverage will reduce on the policy anniversary following your attainment of the ages shown. The percentages referenced are what the coverage reduces to and are all based on the original amount of coverage. For example, if you are covered for $50,000 and the coverage reduces to 65% at age 65, your coverage will reduce to $32,500 on the policy anniversary following your 65th birthday.
Is the accidental death benefit in addition to the life benefit?	Yes, if the insured dies as a result of a covered accident, the beneficiary will receive both the life and accidental death benefits.
How do I convert my coverage?	Contact your employer's HR department for the applicable conversion forms. You can also call Equitable customer service at (866)274-9887 or access the forms at https://equitable.com/employee-benefits/customer-service/forms
How do I name a beneficiary?	Your employer will provide you with a form that will allow you to name primary and contingent beneficiaries.
Can I change my beneficiary?	Yes, you just need to complete a new beneficiary form and be sure to provide a copy to your employer.

What happens if I die and didn't name a beneficiary?

The insurance proceeds will be paid out as follows if there is no beneficiary designated or living:

- To your spouse
- To your surviving children in equal shares, if there is no surviving spouse
- To your parents in equal shares, if there is no surviving spouse or children
- To your brothers and sisters in equal shares, if there is no surviving spouse, children, or parents
- To the executors or administrators of your estate, if there is no surviving spouse, children, brothers, sisters, or parents.

Contact us at (866) 274-9887 with any questions you may have.

This includes questions on how we can provide language translation services at no cost to you and how we can assist the visually impaired with form completion and other information.

Email: Customer Service at EBCustomerService@equitable.com.

Members requiring assistance with hearing impairment can contact our TDD line directly at (800) 877-8973.

Visit **equitable.com/employeebenefits** and log on to EB360® to view your account details.

[1]2022 Insurance Barometer Study, Life Happens and LIMRA.
[2]limra.com/en/newsroom/news-releases/2021/industry-associations-unite-to-help-address-the-life-insurance-coverage-gap-in-the-united-states/, accessed August 2022.

Important Information

Limitations and exclusions: The following is a summary. A complete list of applicable exclusions and limitations are included in the policy and certificate. State variations may apply. AD&D Benefits may not be payable for injuries caused or contributed to by or incurred: physical or mental illness or disease or related medical treatment, infection not occurring as a direct result of accidental bodily injury, suicide or intentionally self-inflicted injury, war or act of war, while incarcerated, participating in a felony or illegal activity, intoxication, voluntary drug use unless administered by and used as instructed by a physician or for over-the-counter drugs in accordance with manufacturer's instructions, participation in certain activities involving an increased risk of injury as listed in the policy and certificate (ex: mountain climbing, sky diving).

This policy provides limited benefits: The policy has limitations and exclusions. Optional riders and/or features may incur additional costs. For costs and complete details of the coverage, please see the actual policy or contact your benefits representative. Benefits payable are subject to all terms and conditions of the certificate. Plan documents are the final arbiter of coverage. Policy contract forms: ICC18 MOEBPLI; ICC18 AXEBPLI; MOEBP0618 LI; AXEBP0618 LI; and state variations.

Legal disclosures: Equitable is the brand name of the retirement and protection subsidiaries of Equitable Holdings, Inc., including Equitable Financial Life Insurance Company (Equitable Financial) (NY, NY); Equitable Financial Life Insurance Company of America (Equitable America), an AZ stock company with main administrative headquarters in Jersey City, NJ; and Equitable Distributors, LLC. Equitable Advisors is the brand name of Equitable Advisors, LLC (member FINRA, SIPC) (Equitable Financial Advisors in MI & TN). All group insurance products are issued either by Equitable Financial or Equitable America, which have sole responsibility for their respective insurance and are backed solely by their claims-paying obligations. Some products are not available in all states.

EQUITABLE

EQUITABLE | AXA

Group name: Porter County Government
Policy number: 017422
Effective date: 01/01/2024

Emergency travel assistance program

Emergency travel assistance program benefit summary

Your well-being doesn't begin or end with your finances. It starts with — and is always about — you.

Contact AXA Assistance USA 24 hours a day, 7 days a week

Within the United States
(855) 327-1476

Outside the United States
1 (312) 356-5980

Emergency Travel Assistance Program Features

Class definition: Class 1 – All Active Full Time Employees

Coverage details

Emergency Medical Transportation	• Emergency medical evacuation • Medical repatriation • Return of mortal remains • Transportation of travel companion • Transportation of family member to accompany patient • Escort of dependent children
Medical Assistance	• Medical and dental referrals • Coordination of hospital admission • Critical care monitoring • Dispatch of physician • Dispatch of prescription medication

Emergency Travel Assistance Program Features

International Medical Teleconsultation	24/7 Medical care at your fingertips. With the international medical teleconsultation service, you and your family can receive virtual medical care when traveling abroad. For minor ailments and conditions, licensed medical practitioners provide Medical advice, treatment options, assistance with prescription refills and provider referrals, through your smartphone or tablet.
Travel Assistance Services	• Lost document and luggage assistance • Emergency cash/bail assistance • Emergency message transmission • Legal referrals • General travel information
Identity Theft	You also have access to identity theft assistance while at home or traveling. This service provides: • Awareness and education: Providing you with a guide on identity theft. • Recovery and resolution: Guidance in taking the necessary steps if your identity is compromised.
Concierge Services	Make your life simpler and easier. Concierge services are designed to fulfill various travel and entertainment requests, including restaurant and entertainment recommendations, locating available business services, airfare and car rental, and much more.

Understanding your benefits

Frequently Asked Questions

How can I access the Travel Assistance services?	• Inside the United States call (855) 327-1476 • Outside the United States call 1 (312) 356-5980
Are the services provided confidential?	Yes, all services provided through this program are confidential.
Do I need to be traveling outside the United States to access the travel assistance services?	No, you can access the travel assistance services any time you are travelling 100 or more miles from your primary residence as long as the trip is less than 120 days.
Can I call at any time?	Yes, access to consultants is available 24 hours per day, 7 days per week.
Is there a limit to the number of times I can utilize the service?	No, you can call as many times as needed.
Will I be charged for these services?	No, as long as they are authorized and arranged by AXA Assistance USA. You may responsible for additional costs for services not covered under this program.
Can I arrange and pay for services myself and then request reimbursement?	No, all travel assistance services must be authorized and arranged by AXA Assistance USA.

Contact us at (866) 274-9887 with any questions you may have.

This includes questions on how we can provide language translation services at no cost to you and how we can assist the visually impaired with form completion and other information.

Email: Customer Service at EBCustomerService@equitable.com.

Members requiring assistance with hearing impairment can contact our TDD line directly at (800) 877-8973.

Visit equitable.com/employeebenefits and log on to EB360® to view your account details.

Important Information

Travel assistance services are considered non-insurance services and are provided by AXA Assistance USA, Inc. Certain benefits provided under the Travel Assistance Program are underwritten by licensed third-party insurance company. The Travel Assistance Program and services provided are separate and apart from the insurance provided by Equitable Financial. Please review the terms and conditions of the Travel Assistance Program for more information. Equitable Financial is not affiliated with AXA Assistance USA, Inc.

Legal disclosures: Equitable is the brand name of the retirement and protection subsidiaries of Equitable Holdings, Inc., including Equitable Financial Life Insurance Company (Equitable Financial) a (NY, NY); Equitable Financial Life Insurance Company of America (Equitable America), an AZ stock company with main administrative headquarters in Jersey City, NJ; and Equitable Distributors, LLC. Equitable Advisors is the brand name of Equitable Advisors, LLC (member FINRA, SIPC) (Equitable Financial Advisors in MI & TN).

EQUITABLE

IMPORTANT NOTICES

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). To be eligible for these Special Enrollment rights you must have completed a waiver when you were first eligible stating that you were declining because of other group health insurance coverage.

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 your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the case of marriage, eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins.

Women's Health & Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, benefits under this Plan are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following Covered Charges, as you determine appropriate with your attending Physician: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and treatment of physical complications of the mastectomy, including lymphedema. The amount you must pay for such Covered Charge (including Copayments and any Deductible) are the same as are required for any other Covered Charge. Limitations on benefits are the same as for any other Covered Charge.

Patient Protection Notice

Porter County Government generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Apta Care Coordinators at 877-610-8817.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Apta Health or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Apta Care Coordinators at 877-610-8817.

Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at (260) 434-0909 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of Porter County Government and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

(1) your past, present, or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact Human Resources at 888-888-8888.

Effective Date

This Notice is effective September 23, 2013.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by internal company email.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations
In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law-enforcement official-

- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:
(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures
The following is a description of disclosures of your protected health information we are required to make.
Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures
Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:
(1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
(2) treating such person as your personal representative could endanger you; and
(3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights You have the following rights with respect to your protected health information:
Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to Human Resources. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to Human Resources.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.
To request an amendment, your request must be made in writing and submitted to Porter County Government HR at 155 Indiana Avenue, Valparaiso, IN 46383. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.
- If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to Human Resources. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.
Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request to Human Resources at (219) 510-6075. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply-for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request to Human Resources at (219) 510-6075 We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
To obtain a paper copy of this notice, contact Human Resources at (219) 510-6075.

Complaints. If you believe that your privacy rights under this Notice have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact Human Resources at (219) 510-6075 or 155 Indiana Avenue, Valparaiso, IN 46383. All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

You may also file a written complaint directly with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Room 509F, Hubert H. Humphrey Building, Washington, D.C. 20201, or the appropriate Regional Office of the Office for Civil Rights. You may also call them at 1-877-696-6775; or by visiting .

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 09-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employmentbased health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Porter County Government HR at (219) 510-6075..

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Porter County Government			4. Employer Identification Number (EIN) 35-6000187
5. Employer address 155 Indiana Avenue			6. Employer phone number 219-510-6075
7. City Valparaiso		8. State IN	9. ZIP code 46383
10. Who can we contact about employee health coverage at this job? Rhonda Young			
11. Phone number (if different from above)	12. Email address ryoung@porterco.org		

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☒ All employees. Eligible employees are:

An eligible Employee is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full-time 30 or more hours per week, this does not apply to elected officials, judges, medical officer-health department, deputy coroners, public defenders, voter registration appointees, elected prosecutor-state Employee, chief deputy prosecutor-state Employee.

☐ Some employees. Eligible employees are:

For purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion: Leased Employees, Independent Contractors as defined in the Plan, Consultants who are paid on other than a regular wage or salary basis by the employer, Members of the employer's Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business on a full-time, regular basis.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Legal spouse, Dependent children to the 26th birthday.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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 **1-877-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 **1-866-444-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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: 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/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

MEDICARE PART D NOTICE

Important Notice from Porter County Government About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Porter County Government 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. If neither you nor any of your dependents are eligible for or have Medicare, this notice does not apply to your or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

There are two 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. Magellan Rx has determined that the prescription drug coverage offered by the Porter County Government Employee Benefit Plan is 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 coverage, you and your dependents will be able to get this coverage back at the next annual open enrollment period.

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 with Porter County Government 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 This Notice Or Your Current Prescription Drug Coverage...
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Porter County Government changes. You also may request a copy of this notice at any time.

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

Date: October 15, 2023
Porter County Government
Porter County Government HR
155 Indiana Avenue, Valparaiso, IN 46383
(219) 510-6075

apta health