

Employee Group Insurance Benefit Handbook



Indiana State
Personnel Department

General Information

The State Personnel Department Benefits Division is responsible for employee statewide benefit programs including medical, dental, vision and life insurance. However, you should understand that the Benefits Division does not make any medical determinations related to your claims. All claims are handled through a third party administrator (TPA) or insurer. The contact information for the third party administrators and insurers can be found on the State Personnel Department's Benefits Division web site (<https://www.in.gov/spd/benefits>). Listed below is the contact information for the Benefits Division.

State Personnel Department
Benefits Division
402 W. Washington St. Rm W161
Indianapolis, IN 46204
(317) 232-1167
(877) 248-0007
spdbenefits@spd.in.gov
<https://www.in.gov/spd/benefits>

Disclaimer

The material contained in this handbook is for informational purposes *only* and is not a contract. It is intended to highlight the eligibility requirements for the insurance plans, as well as explaining the rules governing benefits. If there is any difference between this information and any applicable state or federal law, the law governs. Additionally, should there be a difference between any oral representation provided and any state or federal law, the law governs. It is your responsibility to read all materials provided in order to fully understand the provisions of the option selected.

For questions or concerns regarding:

Eligibility
Enrollment
Qualifying events
Self Service benefits enrollment
General benefit information
ID cards

Contact:

State Personnel Benefits Division
317-232-1167
877-248-0007
spdbenefits@spd.in.gov

For questions or concerns regarding:

Claims
Covered services
Provider networks
Prescription drug coverage
Provider web sites

Contact:

Anthem	877-814-9709
CVS Caremark	866-234-6869
Securian	866-293-6047
ASI Flex	800-659-3035
UMB Healthcare Services	866-520-4472

Employee Responsibilities

Read all the information carefully

It is your responsibility to become familiar with your benefit plans. It is also a good idea to know what services are covered. You should direct your benefit questions to the State Personnel Benefits Division or to the appropriate third party administrator or insurer. All plan summaries and descriptions are available on the Benefits Division web site (<https://www.in.gov/spd/benefits/>).

Plan your decisions wisely

Compare all of your insurance options and determine which option will best suit the needs for you and your family.

Determine the amounts that will be deducted from your paycheck. After you have made your selections at the time of your employment/re-employment, changes can only be made during the annual Open Enrollment or if you experience a qualifying event.

Verify that your insurance deductions are correct

Enrolling in Self-Service Benefits through PeopleSoft® will provide you with a benefit confirmation statement showing a summary of your elections. Be sure to print and review your confirmation and make sure all your elections are correct. Review your first paycheck and make sure all your deductions are correct. If you notice any discrepancies, contact the State Personnel's Benefits Division. If there is a discrepancy in your benefit deductions, appropriate action will be taken to ensure that your deductions are correct.

Eligibility

Employee eligibility

All active, full-time employees and elected or appointed officials are eligible to participate. For the purpose of benefits eligibility, full-time employees are defined as active employees whose regular work schedule is at least 30 hours per week. Part-time, intermittent, and hourly (temporary) employees who work an average of 30 or more hours per week over a 12-month review period are also eligible for benefits. Part-time, intermittent, and hourly (temporary) employees working less than 30 or more hours per week over a 12-month review period are not eligible for insurance or related benefits.

Eligibility for life insurance

Upon your employment/re-employment, you are in your initial enrollment period for life insurance. During your initial enrollment period, you may elect any life insurance option offered for you and your dependents. Life insurance options include:

- Basic Life
- Voluntary AD&D (up to \$500,000)
- Supplemental Life (up to \$200,000)
- Spouse Life (up to \$20,000)
- Child Life (up to \$20,000)

After the initial enrollment period, you may apply for coverage and/or increase coverage by submitting Evidence of Insurability for approval. Submitting Evidence of Insurability paperwork does not guarantee approval of life insurance coverage.

Child dependent life and voluntary AD&D are always guaranteed meaning you may enroll in these coverages at any time if you are currently enrolled in basic life by contacting the State Personnel Benefits Division.

Dual coverage

Dual coverage of the same individual is not allowed under the state's medical, dental and vision benefit plans. For example, if both you and your spouse are state employees with insurance coverage (or one is a current employee and the other is a retiree), you may not cover each other on both plans or have the same children on family coverage. This also applies to parents of children who are not married to each other. You may each elect a single plan, one may carry family and the other may waive coverage, or one may carry family with the children and the other carry single coverage.

A second example occurs when an employee who has retired from one area of state employment begins active work in another state position. In this instance, you have the choice to continue your retiree coverage and waive your active employee coverage, or vice versa. However, you are not permitted to carry state retiree insurance and active state employee coverage simultaneously. Dual coverage is only permitted for dependent life.

Eligible dependents

Dependents of eligible employees may be covered under the State's benefit plans. In order for dependents to be covered, the employee must be covered. Dependents are defined as:

Spouse: An individual to whom you are legally married. IC 31-11-8-5 provides: a marriage is void if the marriage is a common law marriage that was entered into after Jan. 1, 1958. Employees are not allowed to claim dependents based on common law marriages. An ex-spouse is not eligible for coverage even if court ordered.

Children: Natural-, step-, foster, or legally adopted children; children who reside in the employee's home for whom the employee or spouse has been appointed legal guardian or awarded legal custody by a court, until the end of the month in which they turn 26.

Age limitation: Dependent children are eligible for coverage until the end of the month in which they turn 26.

In the event a child:

- i.) was defined as a “dependent”, prior to age 19, and
- ii.) meets the following disability criteria, prior to age 19:

- (I) is incapable of self-sustaining employment by reason of mental or physical disability,
- (II) resides with the employee at least six (6) months of the year, and
- (III) receives 50% of his or her financial support from the parent

such child’s eligibility for coverage shall continue, if satisfactory evidence of such disability and dependency is received by the State or its third party administrator in accordance with disabled dependent certification and recertification procedures. Eligibility for coverage of the “Dependent” will continue until the employee discontinues his coverage or the disability criteria is no longer met.

A dependent child of the employee who attained age 19 while covered under another health care policy and met the disability criteria specified above, is an eligible dependent for enrollment so long as no break in coverage longer than 63 days has occurred immediately prior to enrollment. Proof of disability prior to age 19 and proof of prior coverage will be required. The plan requires annual documentation from a physician after the child’s attainment of the limiting age.

Please Note: If you wish to enroll a dependent onto your plans who is over the age of 26 and meets the definition of a disabled dependent but has not been certified with Anthem, please call the Benefits Hotline at 317-232-1167 or toll free at 877-248-0007, if outside the 317 area code, to initiate the disabled dependent certification process. You must contact the Benefits Hotline within 31 days after a disabled dependent turns 26 to ensure that there is no lapse in coverage. Failure to contact the Benefits hotline timely will result in automatic removal. To be eligible to enroll your dependent(s) as part of your Open Enrollment event, you must contact the Benefits Hotline during

Open Enrollment and Anthem must certify that your dependent(s) meets the definition of a disabled dependent.

Examples of persons NOT eligible for coverage as a dependent

- Ex-spouse
- Live-in boyfriends or girlfriends
- Parents or parents-in-law
- Grandchildren (unless employee is the court-appointed legal guardian or custodian)
- Adults under guardianship of employee
- Dependents older than the end of the month in which they turned 26 that are not disabled
- Any other members of your household who do not meet the definition of an eligible dependent

Penalty for dishonesty

Falsifying information/documentation in order to obtain/continue insurance coverage is considered a dishonest act and could lead to discipline and criminal prosecution. Inadvertent or negligent failures to update or correct information related to eligibility of the employee or listed dependents are also subject to penalty. You are responsible for updating dependent information within 30 calendar days of the occurrence of any event affecting eligibility, for example, when a divorce severs a marital relationship or if a dependent gets married. The State of Indiana will impose a financial penalty, including, but not limited to, repayment of all insurance premiums the State made on behalf of the employee and/or dependent, as well as any claims paid by the insurance companies. Disciplinary action up to and including dismissal may also be imposed if appropriate.

Enrollment

Enrolling at hire

For employees paid by through the Auditor of State, health care coverage begins four days after your first payroll deduction. For employees in a direct bill agency, coverage begins the first day of the month following your date of hire. A direct bill agency is an agency that is not paid by the Auditor of State. In accordance with the State's contracts with the carriers, elections must be made and submitted no later than the Monday following the pay period in which you were hired. If you are an employee of a direct bill agency, your elections must be submitted no later than the Monday following the pay period in which you were hired, using the Auditor of State payroll schedule. If your elections are not submitted by the deadline, your next opportunity to enroll will be during the annual open enrollment period. Different rules apply to elected officials. Elected officials and legislators must enroll by January 31 of the year following their election/re-election.

Enrolling/making changes during open enrollment

Open enrollment occurs every year and is usually held around November. During open enrollment, you are given the opportunity to make changes to your current elections, add or drop dependents and enroll in coverage. All changes made during open enrollment become effective on January 1 of the following year.

To make changes during the open enrollment period, you must access PeopleSoft® and complete the open enrollment process within the designated time frame. Once the deadline has passed, you will not be able to make changes to your benefits until the next open enrollment unless you have a qualifying event, sometimes referred to as a family status change or life event.

Enrolling/making changes due to a qualifying event

If you have a family status change, you must report it to the Benefits Hotline within 30 calendar days of the qualifying event. Documentation to support your family status change must also be submitted within 30 days of your notification to the Benefits Division. It is important to note that a qualifying event will not allow you to change the plan that you are currently enrolled in but will allow you to change your level of coverage.

A qualifying event may include, but is not limited to, the following:

- Change in legal marital status – Marriage, divorce, legal separation, annulment or death of a spouse
- Change in number of dependents – birth, death, adoption, placement for adoption, award of legal guardianship or custody
- Change in employment status of the employee’s spouse or employee’s dependent – switching from part-time to full-time employment status or from full-time to part-time, termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence which results in employee/dependent becoming ineligible for coverage
- Dependent satisfies or ceases to satisfy eligibility requirements – dependent reaches limiting age

Effective date of change

The effective date of the change is based on the type of qualifying life event and your previous coverage at the time of the event. Depending on your specific situation the coverage would change on the date of the event, four days after your first deduction, or 18 days after your last deduction. For employees in a direct bill agency, your coverage will be effective the first day of the month following the qualifying event or the date of the event, in specific situations. If you have specific questions regarding a qualifying event contact the State Personnel Benefits Division.

Federal IRS Irrevocability Rule - Limitations on enrolling/making changes - Penalties

Employee payroll deductions for insurance premiums receive tax-exempt status under Section 125 of the Internal Revenue Code. Plans with tax exempt employee contributions are prohibited from allowing changes in coverage: (1) except during one annual enrollment period; or (2) when the employee experiences a qualifying event. These limitations on enrollment and changes are strictly enforced because the State could lose its special tax treatment for failure to strictly enforce these limitations and individual employees may be subject to IRS audit which could result in payment of additional taxes and/or other penalties.

This irrevocability rule applies to both increases and decreases in coverage, such as adding or dropping dependents from the health coverage or increasing or decreasing employee life insurance coverage. If you have a qualifying event, and fail to make the relevant changes in your coverage within 30 calendar days, you are prohibited from making those changes until the next annual open enrollment period. Consequences of that failure include loss of coverage for otherwise eligible dependents that were not added within the time limit.

You must contact State Personnel Benefits to remove dependents who no longer meet eligibility previously mentioned (Ex-spouse, lost guardianship on ward, etc.). Even outside of 30 calendar days, these life changing events **must still** be reported to remove ineligible dependents from your coverage. Failure to remove ineligible dependents within the time limit can lead to penalties including disciplinary action or prosecution.

Medicare

When you turn age 65, you become eligible to enroll in Medicare benefits. If you wish to enroll, you should contact your local Social Security office within one month of reaching age 65. However, you may also decide to delay enrollment in Medicare until your coverage under the State of Indiana group health plan terminates. Once you are no longer covered under the group health plan, you may enroll in Medicare without premium penalty. You will need to elect coverage within a seven month enrollment period beginning with the first day of the first month in which you are no longer enrolled in a group health plan.

Coordination of Benefits

Any benefits covered under both the States plan and Medicare will be paid pursuant to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services (CMS) guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions, and federal law.

Health Savings Account

According to IRS regulations, an individual who is enrolled in Medicare (Part A or B) is not eligible to make or receive contributions into a Health Savings Account (HSA). There are tax consequences to the individual and the employer, if the employer is also contributing to an HSA for the employee. If you enroll in Medicare and are receiving HSA contributions, you must immediately contact the State Personnel Benefits to stop the contributions.

If you elect to receive Social Security Benefits at age 62 or older, you are automatically enrolled in Medicare Part A upon turning 65. If you wish to participate in the HSA, enrollment in Social Security retirement benefits and Medicare should be declined. Please note that there could be potential consequences if you choose to decline enrollment once you have started receiving benefits. Additionally, if Medicare is not taken when you first qualify, when applying for Social Security Benefits, Medicare Part A may backdate up to 6 months.

Although, once Medicare is elected, you can no longer make contributions into your HSA, the money that has accumulated in that HSA from past years remain yours to spend, tax-free, on eligible expenses, including Medicare co-payments or deductibles, vision expenses and dental expenses. Account holders over the age of 65 also have the option to withdraw the money for any purpose and pay only the income tax without penalty.

Eligibility is dependent on the policy holder. Contributions can be made into the HSA if a spouse is covered by Medicare. Funds in this account can be used to pay for eligible medical expenses for dependents (as defined by the federal regulations). If a spouse is on Medicare, he/she is not eligible to contribute to an HSA in his/her name, regardless of whether or not he/she is covered under the medical plan.

The same rules also apply if you receive Social Security disability benefits and are enrolled in Medicare.

Disclaimer

The Medicare information in this handbook is for informational purposes only. If there is any difference between the information in this handbook and information provided by the Social Security Administration, which manages Medicare, the Social Security Administration governs.

Claims Process

In-network vs. out-of-network

In-network health care providers are those who have contracted with the third party administrator or insurer and agreed to accept a certain amount as payment in full for specific covered services.

Out-of-network health care providers have no contract with the third party administrator or insurer. They may charge more for specific services than what the in-network providers will accept. Most Preferred Provider Organization (PPO) plans pay a portion of out-of-network claims but not at the same amount as an in-network provider.

Plan year deductible

Before benefits are payable under your benefit plan, you must first satisfy the deductible for services. The deductible requirement applies to all services unless otherwise noted on the benefit summary of your specific plan. The plan year deductible also applies towards satisfying the out-of-pocket maximums. Once the deductible is met the coinsurance or co-payments begin.

Out-of-pocket maximums

The out-of-pocket maximum includes the deductible, co-payments and coinsurance you incur in a benefit period unless otherwise noted on the benefit summary of your specific plan. Once you and/or your family's out-of-pocket maximum is satisfied, no additional co-payments or coinsurance will be required for you and/or your family. This is true for the remainder of the benefit period, unless otherwise noted on the benefit summary of your specific plan.

Premium Payments

Premium payments for active employees are generally paid through payroll deductions with the employee paying a portion and the State paying the balance of the premium amount. Premiums are paid in advance of coverage. When an unpaid absence lasts a full pay period, no paycheck is issued; therefore, no premium is paid and the benefits affected are the next 18 days after the check date. The following information is regarding continuation of insurance coverage while you are on a leave of absence without pay for at least a full pay period. If you are an employee of a direct bill agency, contact your payroll department for specific dates of coverage.

TYPES OF LEAVE

Family/Medical Leave (FML)

You will only be responsible for payment of the employee portions of the premiums. Your portion of the premium payment will be deducted from your paycheck(s) upon return to pay status. The amount deducted from each paycheck will depend upon the number and amount of premiums required to cover the full unpaid absence.

If you do not return to pay status or if any missed premiums are not recovered prior to the end of the calendar year through payroll deductions, you will be billed at home by the insurance carrier(s) for your portion of the missed premiums.

Leave of Absence without Pay (LOA)

If you are not on an approved FML or military leave, you will be responsible for paying both the employee and employer portions of the premiums. You will be billed at home by the insurance carrier(s) for the missed premiums.

The maximum time billed for LOA is six pay periods. If the leave extends beyond six pay periods, you will be offered continuation of insurance coverage under COBRA. Contact State Personnel Benefits for more information regarding COBRA.

Military Leave

You may continue insurance and pay the employee portion of the premium for the first 30 days of leave. Beyond 30 days, you have the option to continue insurance while you are out or to terminate benefits during the leave and have them reinstated upon return to work. If you choose to continue the insurance, you will be billed by the insurance carriers for the employee portion of the premiums.

Worker Compensation (WC)

If you sustain a work related injury and are eligible for wage replacement benefits through WC, you will be responsible for only the employee portion of the premiums during the waiting period. You will not be responsible for the employer portion of the premiums.

COBRA

Under federal “COBRA” law, the state of Indiana is required to offer covered employees and covered family members the opportunity for a temporary extension of health coverage (called continuation coverage) at group rates when coverage under the health plan would otherwise end due to certain qualifying events. Each qualified beneficiary has independent COBRA election rights and will have 60 days to elect continuation coverage. The 60-day election timeframe is measured from the later of the date health plan coverage is lost due to the event or from the date of COBRA notification. If a qualified beneficiary does not elect continuation coverage within this election period, then rights to continue health insurance will end and they cease to be a qualified beneficiary. If a COBRA election is made within the 60-day election timeframe and all applicable premiums are paid, coverage will be reactivated back to the loss of coverage date and pending claims will be released for payment.

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), was designed to protect the confidentiality and security of health information and to improve efficiency in healthcare delivery. HIPAA standards protect the confidentiality of medical records and other personal health information by regulating the use, release and disclosure of private health information. The State contracts with health plan administrators and other carriers to provide services including, but not limited to, claims processing, utilization review, behavioral health services and prescription drug benefits.