



The Torch

The official newsletter for Indiana state employees

Open Enrollment Edition

Enroll online starting October 27

This special edition is dedicated to 2022 Open Enrollment. Please review all the enclosed information concerning your health care coverage. During this period, you can choose to make additions or changes to your benefit selections.

All Open Enrollment communications, including carrier information, rates and plan summaries, are posted on the Open Enrollment website: www.in.gov/spd/openenrollment.

This information applies to state employees eligible for benefits and does not apply to conservation officers, excise officers, Indiana State Police plan participants, temporary employees, or contractors.

Discover A New
Level of Savings

2022
Open Enrollment
Oct. 27 – Nov. 17
Deadline is Wednesday,
Nov. 17 by noon ET

Benefit highlights for 2022

What is changing for 2022

- New tiered network options within each medical plan
- Health Savings Account limits increasing
- Prescription 90-day retail plan changes
- Increase to Commuter Reimbursement limit

What is staying the same

- Three statewide medical plans
- Active Employee premiums
- Wellness and tobacco discount amounts
- All three plans have prescription drug plans through CVS Caremark
- Dental premiums and coverage
- Vision premiums and coverage

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The Torch is published monthly by the Indiana State Personnel Department and is available online at on.in.gov/TheTorch.

Got a story?

Submit your story ideas to: spdcommunications@spd.in.gov

Social media



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Follow [State of Indiana Employees](https://www.youtube.com/StateofIndianaEmployees)

Looking for plan rates?

[View the 2022 plan rates >](#) [Download the complete rate chart >](#)

A message from Dr. Box

Open Enrollment: The perfect time to focus on your health and catch up on screenings

Open enrollment is the perfect time to take stock of your health goals for this year and look ahead to the next!

Unfortunately, many Hoosiers have fallen behind on routine health screenings and procedures throughout the COVID-19 pandemic, but there's still time to get that annual physical, mammogram or vaccination. After all, it's never too late to take care of your health.

Preventing illness before it happens is always the best medicine, and we have several safe and effective vaccines that can help you stay healthy all year long.

With flu season upon us, I encourage all Hoosiers to get a flu shot. This year's flu season could be much busier because last year's unprecedented low influenza case volume was influenced by people wearing masks, staying home, and frequently washing their hands due to the pandemic.

The COVID-19 vaccine is also widely available. Remember, it's

safe to get a flu shot and COVID-19 vaccine at the same time. Hospital systems are still strained by COVID-19, and all of us need to do what we can to prevent flu from adding to the burden.

For added protection, Pfizer vaccine boosters are now available for eligible individuals. Other boosters are expected to be available soon, followed by FDA approval of the vaccine for children ages 5 to 11. Check [OurShot.in.gov](https://www.ourshot.in.gov) for the latest news and information, and for a list of vaccination sites near you.

Remember to get other vaccines, including shots for pneumonia, shingles and hepatitis A, if you haven't already.

Please take advantage of these benefits and others available to you as a State of Indiana employee. These benefits can help keep you and your family safe and healthy.

Yours in health,

Kristina M. Box, MD, FACOG
State Health Commissioner

Eligibility for the state's benefit plans

There are no pre-existing condition limitations for any of the state's plans. 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 and intermittent (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 and intermittent (temporary) employees working less than 30 hours per week over a 12-month review period are not eligible for insurance or related benefits.

Last chance to earn gift cards



Submit your wellness visit results to earn a \$100 gift card

If you completed your 2021 wellness visit through your primary care provider, make sure your results are uploaded to the [ActiveHealth portal](#) by Oct. 31, 2021, in order to earn your \$100 gift card.

It typically takes two to four weeks for results to be loaded into the ActiveHealth portal, and the results must be visible in the portal by Nov. 30 to receive your gift card.

Complete a health assessment to earn a \$25 gift card

Log in to your [ActiveHealth portal](#) and complete your health assessment by Nov. 30. It only takes about 10 minutes, and your gift card is available to redeem immediately after completion in your ActiveHealth Rewards Center.

Gift card rewards can be earned by employees and spouses on an Indiana State Personnel Department-sponsored health plan.

Redeem your gift cards

All gift cards must be redeemed from the ActiveHealth portal by Dec. 31, 2021. View the [Guide to Redeeming Gift Cards](#) for more information.

Checklist

The 2022 Open Enrollment checklist

Is your current plan still the right plan for you? Now is the perfect time to review all of the options, take a look at your family's current health and finances, and actively identify the plan option(s) that best meets your needs.

To make the election process easier, a number of resources are available to help you estimate your 2022 expenses, compare plans, and become a more informed consumer. Use this checklist to help guide you through the steps to a successful Open Enrollment:

- Educate yourself about changes occurring January 1, 2022.
- Access your HR PeopleSoft account.
- Confirm or update personal information, including your home and/or mailing address, email address, phone number and ethnic group.
- If you wish to drop your insurance coverage, you will need to log into your open enrollment event and select "waive" on the designated coverage.
- If you are eligible for the 2022 Wellness Premium Discount, your premium will automatically be reduced on which ever medical plan you select.
- Review your eligible dependents and beneficiaries.
 - Enroll all eligible dependents in each benefit plan you choose.
 - Remove ineligible dependents from all of your benefit plans and report their eligibility change to the Benefits Hotline.
 - Update personal information for each dependent and/or beneficiary (information must match what is on their social security card).
 - Add your dependent's social security numbers.
 - For dependent/beneficiary name changes and Social Security corrections, please contact the Benefits Hotline.
- Check your current elections or make new elections. It is important that you review the dependents enrolled on each of your plans.
- If you have a Health Savings Account (HSA), you need to enter your annual contribution amount.
- If you have a Flexible Spending Account (FSA), you need to re-elect or re-state your annual contribution amount.
- If you have a Commuter Reimbursement Account, your contribution will continue for 2022, unless you waive the coverage.
- Review the Non-Tobacco Use Agreement and accept or decline the agreement for 2022.
- Print an **Election Summary** after you have submitted your elections.
- If you have any questions regarding your benefits, please contact the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007 (if outside of the Indianapolis area).

When do my 2022 Open Enrollment changes take effect?

Medical, dental and vision changes/enrollments:

- Effective: Jan. 1, 2022
- First deduction: Dec. 22, 2021 (6 days of 2021 rates; 8 days of 2022 rates)

Flexible Spending Account (FSA), Commuter Benefit Reimbursement Account, and Health Savings Account (HSA) changes/enrollments:

- Effective: Jan. 1, 2022
- First deduction: Jan. 5, 2022

Life insurance changes/enrollments:

- Effective: Jan. 9, 2022
- First deduction: Jan. 5, 2022

For direct bill agency employees, your benefits will be effective Jan. 1, 2022. For deduction information, please see your agency's Payroll Department.

A New

Level of

Savings

2022 Open Enrollment

Oct. 27 – Nov. 17 by noon (ET)

Subscribe to INSPD's communication channels to stay informed about 2022 Open Enrollment.

Publications:

[The Torch](#) • [Around the Circle](#)

Social Media: [Twitter](#) • [Facebook](#)

Web: [Open Enrollment](#) • [Invest In Your Health](#)

Text: [Benefits alerts](#)

Medical Plan Options

Tiered Network: What you need to know

Your medical networks for 2022 will look a little different from what you have today. Educate yourself on these changes so you can make an informed decision on what plan is the right fit for you and your family.

The state continues to offer three plans: Consumer Driven Health Plan 1, Consumer Driven Health Plan 2, and Traditional Plan. Each plan covers the same services and providers. The difference between each plan is:

- **Premium** (cost you pay to have the coverage).


Discover
A New
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Savings

- **Deductible** (amount you must pay, prior to the plan paying)
- **Co-Insurance** (percentage you pay once your deductible has been met).
- **Out-of-pocket maximum** (the most you would need to pay prior to the plan paying 100% of the cost).

New for 2022 is the creation of a tiered network. Within each plan, employees may choose to use any of the network options. Each network has a diverse group of providers that provide all types of services including preventive care, acute care for illnesses, and chronic care. The big difference between the networks is the cost to you.

- [View the plan comparison.](#)

Tier 1 - HealthSync: Lowest Cost Option

To save the most money, use providers within the Tier 1 - HealthSync network. This tier has lower hospital cost plus the lowest deductible, out-of-pocket maximum, and co-insurance.

Tier 2 - In-Network

Tier 2 is your next best option. This tier includes all other in-network providers. In-network providers have a contract with Anthem to provide services at a discount. They cannot bill members above that discounted rate.

Out-of-Network: Highest Cost Option

Out-of-network providers do not have an agreement with Anthem. Providers can charge you any amount for their services. The health plan will only cover the same cost as an in-network provider and you will be balance billed for any cost exceeding that amount.

You can use providers from all tiers at any time during the plan year. The amount you pay for each visit depends on the provider you chose for that visit. Each claim is applied to the deductible and out-of-pocket maximums of all tiers.

Resources

For more information on how claims are paid:

- [Check out this video](#)
- [View the Anthem HealthSync Guide](#)

Contact

If you have questions about your benefits, please contact the Benefits Hotline at 317-232-1167 or toll-free at 1-877-248-0007 if outside of the Indianapolis area.

R/x Coverage

Prescription Drug Coverage



CVS Caremark is the Pharmacy Benefit Manager (PBM) for the State. All three health plans have the same pharmacy benefit.

In-network pharmacies are Tier 1 providers. Prescriptions filled at in-network pharmacies are considered Tier 1 expenses and will count toward both your Tier 1 and Tier 2 deductible and out-of-pocket maximum.

Ninety-day fills at participating retail pharmacies are changing for 2022. You will be able choose 90-day fills at more pharmacies, but the co-pay and co-insurance is a little higher than past years. The cost for 90-day fills at mail order are not changing and have a lower co-pay and co-insurance than 90-

day fills at retail. Below is a look at the prescription drug plan.

CVS Caremark Mail Service / Mail Order Pharmacy

Members that need medication on an ongoing basis can ask their doctor to prescribe up to a 90-day supply, plus refills if appropriate. Examples are ongoing therapies to treat diabetes, high cholesterol, high blood pressure, and asthma. Mail order offers the best value and has the following benefits:

- Medications are shipped standard delivery at no additional cost.
- First-time orders are usually delivered within 10 days after the order is received.
- Refills usually arrive in less time – refills ordered online or via

the CVS Caremark Mobile App are usually delivered within three to five days and refill orders mailed in are usually delivered within six to nine days.

- Medication packages will include instructions for ordering refills, if applicable, and may also include information about the purpose of the medication, appropriate dosage guidelines and other important details.
- You can track your prescriptions and order refills at www.caremark.com, via the CVS Caremark [mobile app](#), or by calling 1-866-234-6869.
- Registered pharmacists are available around the clock for consultation.

Prescription Drug Coverage			
Deductible must be met before coinsurance rates apply			
	Retail Pharmacy Network (Up to 30 day supply)	Mail Service Pharmacy (Up to 90 day supply)	Retail Pharmacy Network (Up to 90 day supply)
Preventive Medicines (mandated by the ACA)	\$0 (no deductible)	\$0 (no deductible)	\$0 (no deductible)
Generic Medicines	\$10 co-pay	\$20 co-pay	\$30 co-pay
Preferred Brand-Name Medicines	20% Min. \$30, Max. \$50	20% Min. \$60, Max. \$100	20% Min. \$90, Max. \$150
Non-Preferred Brand-Name Medicines	40% Min. \$50, Max. \$70	40% Min. \$100, Max. \$140	40% Min. \$150, Max. \$210
Specialty Medicines	40% Min. \$75, Max. \$150 (30 day supply)		

Anthem programs

Anthem offers support to help achieve health goals



The state is committed to providing health plan members with helpful tools in order to achieve a more active and healthy population. All members enrolled in an Anthem plan receive special services in conjunction with the Anthem Health and Wellness Programs.

The Anthem Health and Wellness Programs provide you with support to help you achieve your health goals. Through Anthem's online tool, you have access to resource materials to learn more about health topics and manage any ongoing health issues such as Diabetes, COPD, Cancer, Pregnancy,

Tobacco Use and Weight Management to name a few. To start using the online tools, please go to www.anthem.com,

log in to your account and click the "Care" tab on top of the page and select "Health & Wellness Center."

In addition to the online tools, representatives may contact you directly as part of one of the Health and Wellness programs. These programs include:

- **Case Management:** Licensed health care professionals work with you and your treating providers as needed to develop a Care Management plan to help meet your needs. Case Management is designed to help members optimize their

health care benefits.

- **ConditionCare:** With the guidance of a dedicated nurse team and health professionals you will gain a better understanding of your health, receive help in following your doctor care plan, and learn how to better manage your health.
- **Future Moms:** Provides moms-to-be with telephone access to nurses to discuss pregnancy-related concerns. This program provides the education and tools to help track the pregnancy week-by-week and prepare for the baby.

For more information about these programs please contact Anthem toll-free at 888-279-5449.

EAP is getting a refresh in 2022

The Employee Assistance Program (EAP), is a confidential program designed to help you and your family members with personal challenges. Under the EAP, you can get help navigating life's stresses 24 hours a day, seven days a week, 365 days a year.

Starting January 1, 2022, Optum will be the new EAP vendor. Optum has a broad network of licensed providers that can help you by phone, virtually, or face-to-face.

Look for more information in December about the new program and how to access services. In the meantime, you still have access to Anthem EAP and eight (8) free face-to-face counseling sessions per issue, per year.

To access Anthem EAP, call 1-800-223-7723.

Anthem programs

Customer service redefined

Anthem Health Guide

Did you know that when you call Anthem customer service you will be connected to an Anthem Health Guide? Health Guides can be reached by phone, mobile app, email or even online chat via mobile device or computer. Health Guides work closely with health care professionals, like nurses, health coaches and social workers, to provide personalized and consultative support.

A Health Guide can help you:

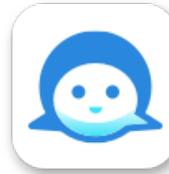
- Connect with the right benefits and programs for your health care needs including any of the Condition Care programs.
- Stay on top of your follow-up and preventive care with reminders and appointment-

scheduling support.

- Compare costs for health care services and find in-network doctors.
- Answer questions about your claims and covered services.

Sydney Health

Another great tool is the Sydney Health app. Sydney Health is your own personal health assistant and benefits guide all rolled into one. Download the app to get started.



Log in using your Anthem User Name and Password from their web portal or register as a new user. With the Sydney app you can:

- Find care and check costs
- View claims
- View and use digital ID cards
- See all of your benefits including your deductible, co-insurance and out of pocket maximum
- Use the interactive chat feature to get answers quickly
- Sync with your fitness tracker
- Check My Family Health Records (myFHR)

Anthem programs

Anthem's 24 hour NurseLine

For those times you are not sure if you need to seek medical care or what level of care is needed, Anthem's NurseLine is available for you. The NurseLine provides anytime, toll-free access to nurses for answers to general health questions and guidance with health concerns.

A nurse can help you understand your symptoms or explain medical treatments. Every caller receives credible, reliable information from a registered nurse.

With the help of NurseLine you can lower your health care costs by finding the appropriate level of care that you may need. Members who use NurseLine are 50% less likely to go to the ER for non-emergency cases. If non-emergency care is received in the ER when a more appropriate setting is available, that claim may be reviewed by a medical director using the prudent layperson standard and potentially denied. However, if you are advised by the NurseLine to seek treatment at the

ER and it is later determined that the visit was for a non-emergent visit, Anthem will cover the visit.

In addition, the NurseLine can also be used to learn more about specific health topics. More than 300 health topics have been prerecorded and are available in both English and Spanish. These recordings are available 24/7 by phone.

To access NurseLine, please call 800-337-4770.

Anthem Programs

Have you tried LiveHealth Online?

LiveHealth[®] O N L I N E

Through LiveHealth Online, you have access to in-network, board-certified doctors 24 hours per day, 7 days per week, 365 days per year. The only thing you need is a computer or mobile device with internet access and a camera.

Doctors on LiveHealth Online are available to diagnose and treat a wide variety of medical care needs. Some common items include the flu, a cold, sinus infection, pink eye, rashes, and fever. When appropriate, the doctor can even prescribe medicine and send the prescription to the pharmacy of your choice.

The average cost of a doctor visit using LiveHealth Online is \$59.

Not only can you be seen by a medical doctor, you can also receive behavioral health services through LiveHealth Online. The behavioral health services can even be used in coordination with the eight (8) free EAP counseling sessions. Below is a quick step-by-step guide on how you can take advantage of the free EAP sessions through LiveHealth Online.

- Call EAP at **800-223-7723** and select option one, State of Indiana Employee Assistance Program.
- Answer some general information, such as your name, date of birth, and address.



- Ask the EAP representative about therapy visits.
- The EAP representative will provide you with a **Service Key** and **Coupon Code** to be used in LiveHealth Online.
- Go to livehealthonline.com.
- Sign up or log in.
 - To Sign up: Download the mobile app from Google Play or the App Store. It is free and takes less than two minutes to download. Or visit www.livehealthonline.com and click the "Sign Up" button at the top right corner of the home page and create an account. All you need to provide is an email address (this becomes your username); create a password; enter your first and last name; sex; state; and agree to the terms of use. You are now registered and ready to connect to a provider.
 - OR, log In by clicking the "Log In" button using your username (email address) and password.
- Select **Add a Service Key** in the **MY Services** section and enter the provided Service Key.
- Select **Work-Life Solutions EAP**, choose the appointment tab. You can schedule an appointment by Date or Therapist. After scheduling the appointment, you will receive a confirmation email.
- Fifteen (15) minutes before your appointment you will receive a reminder email. To initiate the appointment, you need to click on the "Start Visit" button included in the email.
- Enter the coupon code in the payment screen for each of the eight (8) free visits. This will reduce the member cost share to \$0.
- You will then be connected to the therapist.

Sign up for LiveHealth Online today by visiting www.livehealthonline.com or by downloading the mobile app from your app store.

Vision

Vision Plan – Focus on Saving You Money

Vision and health conditions, such as diabetes and high blood pressure, can be revealed and detected early through a comprehensive eye exam. An annual exam with dilation will only cost you \$10.00 at an in-network provider. Take care of your vision and overall health by taking the initiative to have an exam completed this year.

In addition to the exam, the plan allows for frames every 2 calendar years and lenses, including contact lenses, every calendar year. For frames the plan has a \$150 allowance with a \$25 standard lenses copayment when using an in-network provider.

Freedom Pass

To get the most of your money, you can utilize the Freedom Pass. Under the Freedom Pass, you can purchase frames at Target Optical and only pay up to the \$150 frame allowance. Any balance over the \$150 allowance will be waived. To receive the discount, all you need to do is provide Target Optical with the Offer Code 755285 or the [Freedom Pass Flyer](#).

Fixed Copay

Fixed Copays are another way the state is saving you money. There are fixed costs for premium progressive and anti-reflective lens. Lens upgrades can fluctuate in cost significantly which can result in you spending more. By creating a fixed cost, you are guaranteed to spend only the fixed copay amount. The chart to the right provides an overview of the copay amounts.

To view your current eligibility for an exam, frames, lens or contacts, please follow the following steps.

- Go to www.Anthem.com and log in to your account.
- Place cursor over the “My Plan” drop-down menu on top of the page.
- Click “Benefits” on the drop-down menu.
- Click the box showing your current Vision benefit period.
- Scroll down and click the “View your vision benefit information” link.
- On the new tab, click the “View your Benefits” tab on top of the page.
- Select “Member.”
- Click the “Display Benefits” button on the bottom of the page.
- Under the “Service Eligibility” section, you will find your current

eligibility for an exam, frames, lens and contacts.

Through Anthem Blue View Vision, you and your dependents have a large network of ophthalmologists, optometrists, opticians and retail locations to choose from. To find an in-network provider go to www.Anthem.com. Without logging in, select “Find Care” toward the top of the page. Then select “search as a guest.” Under the drop-down options select “Vision” for type of care, “Indiana” for state, “Vision” for type of plan, and “Blue View Vision Select” for plan/network.

COVERED SERVICES	COPAYMENTS/MAXIMUMS	
	Network Providers	Out-of-Network Providers
Exam: Limited to one exam per Member every calendar year	\$10 Copayment	\$35 Allowance
Prescription Lenses: Limited to one set of lenses per Member every calendar year.		
Basic Lenses (Pair)		
• Single Vision Lenses	\$25 Copayment	\$25 Allowance
• Bifocal Lenses	\$25 Copayment	\$40 Allowance
• Trifocal Lenses	\$25 Copayment	\$55 Allowance
Lens Options: Paid by Member and added to the base price of the lens.		
• Standard Polycarbonate	\$20 Copayment	N/A
• Tint	\$15 Copayment	N/A
• UV Coating	\$15 Copayment	N/A
• Standard Scratch-Resistant Coating	\$15 Copayment	N/A
Progressive Lenses		
• Standard	\$65 Copayment	N/A
• Premium Tier 1	\$85 Copayment	N/A
• Premium Tier 2	\$95 Copayment	N/A
• Premium Tier 3	\$110 Copayment	N/A
• Premium Tier 4	\$175 Copayment	N/A
Anti-Reflective Coating		
• Standard	\$45 Copayment	N/A
• Premium Tier 1	\$57 Copayment	N/A
• Premium Tier 2	\$68 Copayment	N/A
• Premium Tier 3	\$85 Copayment	N/A
Other Add-Ons	20% Retail	N/A
Frames: Limited to one set of frames per Member every other calendar year.	\$150 Allowance, then 20% off any balance	\$35 Allowance

Dental

Dental benefits remain the same for 2022

Good dental health may be more important than you think. Studies have identified a link between oral health and chronic conditions such as heart disease.

The best way to lower your risk is by keeping up on your preventive exams. Under the Anthem Dental Complete plan, your diagnostic and preventive services such as teeth cleanings, periodic oral exam and bitewing X-rays are covered at 100 percent when using an in-network provider. Other in-network services such as fillings, crowns and root canals are covered at 80 percent.

Similar to the other health plans, you can realize the greatest savings by going to an in-network dentist. While network dentists sign a contract with anthem to limit fees, nonparticipating dentists do not have limits on the amount they can charge you for services. If you decide to go to a nonparticipating dentist, be sure you understand your potential out-of-pocket costs before you receive services.

A list of dentists within the Dental Complete network can be found by going to www.Anthem.com. Without logging in, select “Find Care” toward the top of the page.

Then select “search as a guest.” Under the drop-down options select “Dental” for type of care, “Indiana” for state, “Dental” for type of plan, and “Dental Complete” for plan/network.

For 2022, the Dental premiums will remain the same. Please see the below rates.

Dental	2022 Bi-Weekly Rate
Single	\$1.32
Family	\$3.42

More information about dental coverage can be found at: www.in.gov/spd/openenrollment/dental.

PeopleSoft Steps

PeopleSoft login and online self-service instruction guide

You can access your Open Enrollment event 24 hours per day, seven days per week, from Wednesday, Oct. 27 through Wednesday, Nov. 17 at noon (ET). You can access your Open Enrollment event from any computer that allows you access to the internet.

Helpful hints:

1. Your User ID is the first initial of your first name capitalized followed by the last six (6) digits of your PeopleSoft number. If you have forgotten your PeopleSoft number, please contact your agency’s Human Resources Department or the Benefits Hotline for assistance.
2. If you access the state network, the password used to log on to your computer can be used to log into PeopleSoft.
3. For password resets and unlocks, please use the Self Service Password Management tool: <https://www.in.gov/password>.
4. For network connectivity or issues accessing the website, please

contact IOT Customer Service at (317) 234-HELP (4357) or toll-free at 1-800-382-1095, and follow the menu options.

5. When making your elections in PeopleSoft, do not use the BACK / FORWARD arrow buttons at the top of your web browser.
6. Keep in mind you must turn off your “pop-up blocker” in order to print your Benefit Election Summary.
7. For any benefit related questions, please call the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007 (if outside Indianapolis).

IMPORTANT: Once you are satisfied with your Open Enrollment elections, it is essential you submit your elections and print a Benefit Election Summary for your records. As a reminder, the 2022 Non-Tobacco Use Agreement can only be accessed through the Open Enrollment event. Please do not attempt to elect to participate in the 2022 agreement by going through PeopleSoft Self-

Service, as that platform is only used to revoke your current 2021 Non-Tobacco Use Agreement.

Remember, you can access PeopleSoft at any time during the year to review your benefits or update contact information. You may access PeopleSoft through this link: <https://hr.gmis.in.gov/psp/hrprd/?cmd=login&languageCd=ENG&>

To view your current benefit elections, log in to PeopleSoft and follow these steps: click “Main Menu,” click “Self Service,” click “Benefits,” and click “Benefit Summary.” Your 2022 benefits will not be available to view until Jan. 1, 2022.

If you have questions about your elections, contact the Benefits Hotline, 7:30 a.m. to 5 p.m. (ET) Monday through Friday. Call 317-232-1167 within the Indianapolis area or 877-248-0007 toll-free outside of Indianapolis.

Know before you go

Did you know that more than 65% of all emergency room (ER) visits are not for life-threatening illnesses or injuries but for non-emergency medical concerns that could be treated at a doctor’s office or urgent care center? Seeking treatment outside of the ER, will save you both money and time. Below is a quick look at the cost difference among alternative treatment facilities.

Non-emergency services are not covered when treated in an emergency room (ER), if more appropriate settings are available.

ER claims are reviewed by Anthem using the prudent layperson standard and may be denied. If your claim is denied, you will be solely responsible for the ER charges. Please note, that non-emergency visits to the ER will be covered if:

- Directed to the emergency room by another medical provider
- Services were provided to a child under the age 14
- There isn’t an urgent care or retail clinic within 15 miles
- Visit occurs on a Sunday or major holiday

When seeking medical care, it is important that you consider all your options. Below is a brief overview of each alternative.

Every time you need care:



STOP



Review options



Save money

Options for care	Nurseline	LiveHealth Online	Retail Health	PCP	Urgent Care Center	Emergency Room
Cost*	Free	\$59	\$70	\$105	\$147	\$1,636
When you have...	Flu-like symptoms, allergies, fever, eye or sinus pain, rash	Flu-like symptoms, allergies, fever, sinus pain diarrhea, eye infection, rash	Sore throat, earaches, bumps, minor cuts and scrapes, UTI	Mild asthma, flu-like symptoms, fever, sprains, eye or sinus infection, sore throat, earache, other non-emergency symptoms	Sprains and strains, ear or sinus pain, minor allergic reactions, cough, sore throat, minor headache, UTI	Signs of a heart attack, difficulty breathing, severe burn or bleeding, and any other symptoms that are life-threatening

**Rates are national averages of the total cost, not what members paid. Your actual cost may vary depending on your plan and where you go for care.*

As a reminder, Anthem’s NurseLine is available 24/7 for those times you are not sure where you should seek medical care. If you are advised by the NurseLine to seek treatment at the ER and it is later determined that the visit was for a non-emergent visit, Anthem will approve the visit. To access NurseLine, please call 800-337-4770.

Health Savings Account (HSA)

State to contribute to Health Savings Account

The state will contribute approximately 56 percent of the Tier 1 - HealthSync annual deductible to your Health Savings Account (HSA) in 2022. The initial contribution will be made on your January 5, 2022, paycheck. Employees enrolled in a CDHP effective from January 1, 2022, through June 1, 2022, receive the full pre-fund amount. CDHPs effective after June 2, 2022, but before December 2, 2022, receive one-half of the initial contribution. The initial pre-fund contribution is based on the coverage type (single/family) that is effective January 1, 2022, or your first day of coverage in a state health plan during 2022.

If you have an active HSA with The HSA Authority at Old National Bank and wish to continue receiving the state's contributions in 2022, you do not need to open a new HSA account. **Employee HSA contribution amounts do not carry over from year to year, if you would like to contribute to your account during 2022, you need to access your PeopleSoft record and enter your desired contribution.**

If you are electing to participate in an HSA for the first time in 2022, you must edit the online HSA option in PeopleSoft and choose the HSA that corresponds to your medical CDHP election to receive the state's contribution. In addition to electing

Plan	2022 Initial Contribution	2022 Bi-Weekly Contribution	Annual Employer Contribution
HSA 1 Single	\$562.38	\$21.63	\$1,124.76
HSA 1 Family	\$1,124.76	\$43.26	\$2,249.52
HSA 2 Single	\$393.90	\$15.15	\$787.80
HSA 2 Family	\$787.80	\$30.30	\$1,575.60

the HSA option, you need to open an HSA account with The HSA Authority before January 1, 2022.

Reminder, to be eligible for an HSA you: Must be currently enrolled in an HSA-qualified health plan;

- May not be enrolled in any other non-HSA qualified health plan;
- May not have, or be eligible to use, a general purpose Flexible Spending Account (FSA);
- Cannot be claimed as a dependent on another person's tax return;
- You may not be enrolled in Medicare at any time, including Part A. If you begin receiving Security monetary benefits prior to age sixty-five (65), Part A is automatic when you turn age sixty-five (65). If you receive Social Security Disability benefits, you may be enrolled in Medicare Part A.
- May not be enrolled in Medicaid, HIP or Tricare;
- Must not have used VA benefits for anything other than preventative services in the past three months.

- Please note: veterans with a disability rating are eligible to participate in an HSA if all of the other criteria are met.

To open your HSA, link to The HSA Authority's website from PeopleSoft on your HSA election page or go directly to www.theHSAauthority.com and click on the "OPEN AN HSA" button. The first page of this online session says: If you have been instructed by your employer to visit this site to open your HSA, click this button and insert your employer code below. Enter **100366** in the "employer code" to begin the state application.

You need the following information to complete the HSA application online:

1. Unexpired government issued ID for account holder and authorized signer, if elected. This can be a driver's license, state issued ID, passport, or military ID.
2. Date of birth for your beneficiaries.
3. Social Security number and date of birth for authorized signer, if elected.

HSAs have a maximum contribution limit

Contributions are allowed up to the maximum statutory limit. The maximum annual contribution for 2022 is \$3,650 for self-only policies and \$7,300 for family policies.

Individuals age 55 and over may make an additional catch-up contribution of up to \$1,000 in 2022.

Combined household contributions

cannot exceed the family limit. The maximum includes the state's contributions and any other contributions to your HSA.

Plan	Coverage	IRS Maximums	State Contribution	Max EE Contribution	Max Bi-Weekly	Max EE Contribution Over 55	Max Bi-Weekly Over 55
HSA 1	Single	\$3,650	\$1,124.76	\$2,525.24	\$97.13	\$3,525.24	\$135.59
	Family	\$7,300	\$2,249.52	\$5,050.48	\$194.25	\$6,050.48	\$232.71
HSA 2	Single	\$3,650	\$787.80	\$2,862.20	\$110.09	\$3,862.20	\$148.55
	Family	\$7,300	\$1,575.60	\$5,724.40	\$220.17	\$6,724.40	\$258.63

Health Savings Account (HSA)

Medicare, Medicaid and HIP disqualify you from having a Health Savings Account (HSA)

The IRS established Health Savings Accounts (HSAs) as a method to provide individuals a tax advantage to offset their health care costs. In doing so, the IRS created eligibility criteria to qualify for the account. Enrolling in Medicare, Medicaid, or HIP 2.0 disqualifies you from having contributions into an HSA. Once enrolled in any of these plans, you may not receive or make any contributions into an HSA.

Although you can no longer make contributions to your HSA once you are covered by Medicare, Medicaid, or HIP 2.0, the money accumulated in your HSA from past years remains yours to spend, tax-free, on eligible expenses, including Medicare copays or deductibles, vision expenses, and dental expenses. If you are age 65 or over, you also have the option to withdraw the money for any purpose and pay only the income tax without penalty. The same rules also apply if you receive Social Security disability benefits and are enrolled in Medicare.

Please review this information carefully as it relates to your eligibility to qualify for an HSA.

Medicare

If you elect to receive Social Security Benefits, you are automatically enrolled in Medicare Part A when you turn age 65. If you wish to participate in a Health Savings Account (HSA), you should decline to receive Social Security retirement

benefits and waive Medicare Part A. Keep in mind there are potential consequences if you choose to decline or postpone your enrollment. Additionally, if you decided not to take Medicare when you first qualify, please be advised that your Medicare Part A start date may backdate up to six (6) months when you apply for Social Security benefits. Please carefully research all of your options before making your decision.

You can use funds in your HSA to pay for incurred eligible medical expenses for your dependents (as defined by federal regulations), even if they are not covered under your medical plan, or have other coverage, such as Medicare. However, keep in mind that if your spouse is on Medicare, she/he is not eligible to contribute to an HSA in her/his name, regardless of whether or not she/he is covered on your medical plan.

Medicaid and HIP 2.0

According to IRS regulations, an individual who is enrolled in Medicaid or HIP 2.0 is not eligible to make or receive contributions to an HSA. There are tax consequences to both the individual and the employer, if the employer is also contributing to an HSA for the employee. Similar to Medicare, if your dependent(s) is/are covered by Medicaid or HIP 2.0 but you are not, you may continue to receive contributions to your HSA. Eligibility is based on the subscriber/ account holder.

Federal Notice

State plans provide creditable coverage

If you are Medicare-eligible, there are two important things you need to know about your current coverage and Medicare's prescription drug coverage. First, 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 (Medicare Part D) 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.

Second, it has been determined that the prescription drug coverage offered as a part of the State of Indiana employee health plans 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.

If you are considering joining Medicare's prescription drug coverage, 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. For more information about Medicare's prescription drug coverage please visit: www.medicare.gov.

Flexible Spending Account (FSA)

Flexible Spending Accounts

A Flexible Spending Account (FSA) provides another opportunity for you to better control your health care dollars. By tucking away pre-tax dollars from your paycheck, you have an account that is dedicated to the reimbursement of qualified medical, vision and dental expenses. In addition, the bi-weekly employee administration fee is paid by the state during the 2022 plan year, providing you with even more opportunities to save.

Through ASIFlex, the state will continue to offer three types of FSAs: Medical Care, Limited Purpose Medical Care, and Dependent Care. If you wish to participate in a FSA for the 2022 plan year, you must re-enroll as your previous election will not roll-over. If you continue participation, do not discard the debit card from ASIFlex. New cards are not automatically issued each year.

As a reminder, all of the state's FSA programs have a use-it-or-lose-it rule. Money left at the end of the plan year is not rolled over or reimbursed, so plan carefully. Please note, if you have funds remaining in your 2021 account, you may continue to submit claims for reimbursement through ASIFlex until the Grace Period expires.

Medical Care & Limited Purpose FSA

Medical Care FSAs allow employees to use pre-tax dollars to cover health care costs for medical, dental, vision, hearing and other out-of-pocket expenses not paid by insurance. For 2022, the annual contribution limit for the Medical Care and Limited Purpose FSAs will be remain at \$2,750.

A Limited Purpose FSA may only be used for dental, vision and preventive care expenses until the minimum deductible of a Consumer Driven Health Plan (CDHP) is met (\$1,400 for single and \$2,800 for family, per federal regulations). Once the minimum deductible is met, the Limited Purpose FSA can be used as a Medical Care FSA. If you are enrolled in a CDHP with a Health Savings Account (HSA), your FSA automatically becomes a Limited Purpose FSA. You do not need to meet the minimum deductible to use the funds in your Limited Purpose FSA for dental and vision expenses. You can pay for dental and vision expenses from your Limited Purpose FSA at any point during the year.

Dependent Care FSA

A Dependent Care FSA is an alternative to the "Tax Credit" allowed for child/dependent care expenses, allowing for tax savings throughout the year with every paycheck you receive. Dependent Care FSAs are used to pay for dependent care services such as preschool, daycare summer day camp, before or after school programs, and child (under the age of 13) or elder daycare.

Dependent Care FSAs are not frontloaded. Portions of your biweekly pay are put into a pre-tax account to pay for eligible dependent care costs throughout the year. Currently the maximum annual contribution amount for the Dependent Care FSA is \$5,000 (\$2,500 if married and filing separate tax returns).

For questions about flexible spending accounts, please review the [2022 FSA Plan Guide](#), or contact the Indiana State Personnel Department's Benefits Hotline at 317-232-1167 or toll free at 877-248-0007 if outside of Indianapolis.

You may also contact ASIFlex customer service via phone at 800-659-3035 Monday through Friday from 8 a.m. to 8 p.m. ET and from 10 a.m. to 2 p.m. ET on Saturday. ASIFlex may also be reached by email at asi@asiflex.com.

New membership ID cards

All State of Indiana health plan participants will receive a new ID card in the mail for the 2022 plan year. Each family member will receive their own unique card prior to January 1 with their name. As in the past, the cards will be used for medical, prescription, dental and vision.

Please continue to use your current card for any health or prescription services received before January 1, 2022. Beginning January 1 please present your new ID card to your provider or pharmacy.

To ensure that you receive your new membership ID card timely, please review and update, as necessary, your contact information within your Open Enrollment event.

Commuter Benefit Reimbursement Account

Commuter Benefit Reimbursement Account

Do you currently commute to work by train, vanpool, subway, or some other type of mass transit? If so, a Commuter Benefits Reimbursement Account may be just what you have been looking for. Through the Commuter Benefits Reimbursement Account administered by ASIFlex, you can set aside money from your paycheck, pretax, to pay for work-related commuting expenses.

Each month you can contribute up to a maximum of \$270. Reimbursements are made from the pretax contributions you previously had deducted from your paycheck. To utilize the benefit, present your ASIFlex debit card as payment to any transit provider who accepts VISA debit cards. You may also seek to be reimbursed by completing a claim form. Reimbursements are made within three days following receipt of the completed claim form. Best of all, you can sign up,

Non-Tobacco Use Incentive

Non-Tobacco Use Incentive

The Non-Tobacco Use Incentive is offered again for the 2022 plan year. Receive a \$35 reduction in your group health insurance bi-weekly premium by accepting the agreement during Open Enrollment. By accepting the incentive, you agree to not use any form of tobacco products in 2022. By accepting the agreement, you agree to be subject to testing for nicotine at any time during the year. If you test positive for nicotine you will be presumed to be in violation of the policy. Tobacco use means any use of tobacco, whether smoked, chewed, sniffed, or ingested in any other manner, including food or drink. Only proof of use of an FDA approved Nicotine Replacement Therapy product will be accepted as evidence to rebut the presumption of a breach.

For more information on FDA approved Nicotine Replacement Therapy Options, [visit the FDA's website](#). **Vaping and e-cigarette products are not FDA approved nicotine replacement therapy products.**

change your contribution amount, or terminate your account at any time by calling the Benefits Hotline.

If you do not spend the full amount you contributed for the month, the money will roll over month to month and year to year. You can then use the funds for future expenses. Claims can be submitted at any point in time as long as you are still actively contributing to the Commuter Benefit Reimbursement Account. Once you terminate your participation in the program, or leave state employment, you must submit all claims within six months of your termination date in order to be reimbursed.

Eligible expenses are those you incur to commute to and from your place of employment. This includes bus, ferry, rail, monorail, streetcar, trolley,

train, subway or vanpool. A Vanpool is considered a highway vehicle with seating capacity of at least six adult passengers. At least 80 percent of the mileage must be for commuting and the number of employees transported must be at least half of the adult seating capacity.

Eligible expenses do not include bicycle or repairs, non-work related parking or transit/vanpool expenses, gas or fuel, tolls, or vehicle repairs.

Please note, if you are already enrolled in the Commuter Benefit Reimbursement Account, your election from 2021 will carry over to 2022, unless you waive your coverage.

For more information about the Commuter Benefit Reimbursement Account, please contact ASIFlex at asi@asiflex.com or by phone at 800-659-3035.

The Non-Tobacco Use Incentive is only available to employees who have enrolled in medical coverage. You do not have access to the agreement if you waive medical coverage for plan year 2022. The reduction in your group health insurance bi-weekly premium only applies to your employee medical premium, and does not apply to dental, vision or life insurance premiums.

If you accept the Non-Tobacco Use Agreement (NTUA) during Open Enrollment and later use tobacco or otherwise breach the NTUA, your employment will be terminated, for breach of the agreement and inappropriately taking the \$35 bi-weekly premium reduction. The only exception to the job loss penalty is if you revoke the NTUA by logging in to PeopleSoft and completing the self-service process to change your agreement prior to the use of any tobacco product. If you need to revoke your agreement and are not sure how to complete the process in

PeopleSoft, call the Benefits Hotline and a specialist can walk you through it. If you revoke the NTUA, you are responsible for paying the value of the incentive you have received for the year. The \$910 is a great incentive, **but it certainly isn't worth losing your job.**

If you use FDA approved nicotine replacement therapy products, please keep all of your receipts for these products and/or copies of prescriptions from your physician to demonstrate your compliance with the NTUA.

The Non-Tobacco Use Incentive does not carry over from year to year. If you want to participate in 2022, you must access your Open Enrollment event within PeopleSoft and accept the NTUA.

Notice: If your physician determines abstaining from the use of tobacco is not medically appropriate, a reasonable alternative standard is made available for the incentive.

Life Insurance

Review & update your life insurance beneficiary information

Open Enrollment is a great time to review your current life insurance beneficiary information. It only takes a couple of minutes to verify your beneficiary designations and update their contact information in your Open Enrollment event. By routinely checking this information you are assuring you have allocated your life insurance benefits as desired, since certain life events such as marriage, divorce, birth or death may change how you want your benefits paid out.

In addition to confirming your beneficiary allocation, you should also update their contact information. It is extremely important PeopleSoft has the correct addresses and phone numbers for all of your beneficiaries. This information is used to identify and locate your designated beneficiaries if a claim is processed. Without updated contact information, it may take a

significantly longer period of time to pay out a claim.

Notify your Beneficiaries

Once you have designated your beneficiaries, it is a good idea for you to notify them of your policy and your decision to list them as a beneficiary. Under the Indiana State Personnel Department's policy, we will not share coverage amounts or beneficiary information to anyone besides you as the policy holder. Providing policy information to your beneficiaries prior to a claim occurring makes a difficult situation easier to cope with, especially when dealing with the financial aspect of the loss.

Note: All beneficiary changes made within your Open Enrollment event take effect on January 9, 2022 unless you are employed with a direct bill agency, in which case your changes will be effective January 1, 2022.

Federal Notice

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you 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).

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.

Eligible employees and dependents may also enroll under two additional circumstances:

- the employee's or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the employee or dependent becomes eligible for a subsidy (state premium assistance program)

The employee or dependent must request special enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, contact the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007 if outside of Indianapolis).

Federal Notice

Women's Health & Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. If you would like more information on WHCRA benefits, contact Anthem at 1-877-814-9709.

Life Insurance

Life Insurance - Are you prepared?

Life insurance is something no one wants to think about but is important to have. The State of Indiana makes having coverage easier by offering five types of coverage: basic, supplemental, voluntary Accidental Death and Dismemberment (AD&D), spouse dependent life, and child dependent life insurance. Take the time to review your finances and consider which option and coverage amount is best for you and your family.

Some life insurance changes can be completed within your Open Enrollment event, including:

- Electing or increasing voluntary AD&D coverage
 - Must be currently enrolled in basic life insurance with AD&D
- Electing or increasing child dependent life insurance
 - Must be currently enrolled in basic life insurance with AD&D
- Decreasing your coverage level
- Waiving your life insurance plans
- Updating your beneficiary information and/or allocation amounts
 - All changes are effective in January 2022

Outside of Open Enrollment you may acquire or make changes to your life insurance plans by completing the Evidence of Insurability (EOI) process at any time throughout the year. Allowable changes include enrolling or increasing your coverage level of

Dependent Life Insurance is unbundling

Today, when you purchase dependent life insurance, your spouse and child(ren) must all have the same coverage amount. During open enrollment, spouse and child coverage will be unbundled. This means you can pick a different coverage amount for your spouse and your child(ren).

Now you will be able to elect one

basic, supplemental, and/or spouse dependent life policies.

The EOI application can be completed online at any time. On average the application takes 10 to 30 minutes to complete. Instructions on how to submit EOI through Securian [can be found here](#). Once submitted, Securian reviews your application and informs both you and INSPD Benefits of its decision. If approved, INSPD Benefits makes the appropriate changes to your life insurance plans and starts the premium deductions.

Please keep in mind, you may also make changes to your beneficiary information at any point during the year by accessing PeopleSoft self-service. Instructions on how to change your life insurance beneficiaries [can be found here](#). You are the only one who can change your beneficiary information.

Reminder: Supplemental life insurance is offered to most employees in increments of \$10,000 up to and including \$500,000, regardless of salary level. Employees reaching age 65 or older on or before December 31, 2021, are limited to \$200,000 of supplemental life insurance coverage. Employees reaching age 65 during the plan year are automatically reduced to \$200,000 of supplemental life insurance coverage and their payroll deductions are adjusted accordingly.

amount for your spouse and another amount for child or children. This gives you the option of selecting \$20,000 in spouse coverage and \$5,000 for your child(ren). This change gives you more options to find the best level of coverage for your family.

Make sure you review your dependent life options during Open Enrollment!

Annual Physical

Don't forget to get your annual physical

As we near the end of the year, it is important to remember to set some time aside to get your annual physical, if you have not already done so. It is easy to get in the mindset that you don't need a physical if you don't feel sick. However, having an annual physical is one of the best ways to maintain your health.

Preventive care, such as an annual physical can help identify underlying health concerns before they become a major issue. By routinely visiting your doctor, you can establish a baseline on your health statistics regarding your weight, height, blood sugar, blood pressure and cholesterol. In addition, you are able to keep your doctor informed about your family's changing medical history. By doing so, your doctor will be able to identify any significant changes in your health statistics or concerns based on your family history that could indicate a problem. Once identified, an early treatment plan can be established to prevent the condition from getting worse.

Outside of identifying health conditions, having an annual physical is a great way to ensure that you are up-to-date on all of your vaccinations to maintain your health. Likewise, your doctor can recommend preventive care goals based on your current health to assist you in continuing down a path of healthy living. Overall, an annual physical is one of the easiest things you can do to maintain a healthy lifestyle. To find an in-network doctor near you, please follow the below steps.

- Log in to www.Anthem.com
- Click the "Care & Cost Finder" tab
- Click "Primary care" under the "Other helpful searches and services" section.

Dependent Eligibility

Children covered to the end of the month they turn 26 years of age

Adult children may be covered under the State of Indiana's medical, dental, vision and dependent life insurance plans until the end of the month of their 26th birthday. A dependent's last day of coverage is the last day in the month in which they turn 26. Dependents are offered COBRA when they lose eligibility. Spouses of adult children (deemed children-in-law) and grandchildren are not eligible for this coverage.

We recommend you access PeopleSoft during Open Enrollment to review or edit your dependent information. Keep in mind, you have to enroll your dependents on each plan (medical, dental, and vision) for which you desire coverage.

Disabled Dependents

Disabled dependents can be enrolled in any of your desired plans during the Open Enrollment period if they have not exceeded

the month in which they turn 26 or were approved through the Anthem recertification process. If you wish to enroll a dependent during Open Enrollment who is over the age of 26 and meets the definition of a disabled dependent, but was not certified through Anthem, please call the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007, if outside of Indianapolis.

Upon your request, Anthem will be notified to mail you an Application for Continuation of Coverage. This form must be completed and returned to Anthem within 30 days of the issue date. If Anthem certifies your dependent meets the definition of a disabled dependent, the state will then enrolls your dependent in your plans with the effective date of January 1, 2022.

Please note, you must initiate the certification process by contacting the Benefits Hotline during Open

Enrollment to be eligible to enroll your dependent(s) as part of your Open Enrollment event for an effective date of January 1, 2022.

Outside of Open Enrollment, you may only add a disabled dependent through a qualifying event. Similar to the process outlined above, you must contact the Benefits Hotline to initiate the certification process. Notification must be done within 30 days of the qualifying event.

In order for a disabled dependent to continue coverage past the month in which they turn 26 years of age, you must contact the Benefits Hotline to initiate the certification process. Notification must be done within 31 days from your dependent turning 26-years old. To be eligible, a dependent child must have been deemed disabled prior to age 19. If a dependent child was deemed disabled after age 19, they are not eligible to continue coverage past the month they turn age 26.

Making Changes

Qualifying events allow for changes

After noon (ET) on Wednesday, November 17 you are not able to make further changes to your benefits. This means you must be certain you elect the coverage that is right for you and add all eligible dependents you wish to cover to all plans (health, vision, and dental). After Open Enrollment, you can only make changes in conjunction with a qualifying event.

Qualifying events are regulated and defined by the IRS, including:

- Changes in your legal marital

status (marriage, divorce, separation, annulment or death of spouse).

- Changes in the number of dependents (birth, adoption, placement for adoption or death).
- Changes in employment status for you or your spouse, such as termination of or change in employment, a strike or lockout, or the start or end of an unpaid leave of absence.
- Changes in dependent eligibility status (such as attainment of limiting age).

If you do not report a qualifying event and complete any necessary paperwork within 30 calendar days from the date of the qualifying event, you are not able to add dependents until the next Open Enrollment period. Please note that an ex-spouse is ineligible for coverage as of the day of divorce.

It is important that you report ineligible dependents even if it is beyond the 30 day period to minimize recovery of claims.

Coverage

Make sure your dependents are eligible

Dependents of eligible employees may be covered under the state's benefit plans. Please see the below definition of a dependent.

(1) "Dependent" means:

- (a) Spouse of an employee;
- (b) Any children, step-children, foster children, legally adopted children of the employee or spouse, or 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, under the age of twenty-six (26). Such child shall remain a "dependent" for the entire calendar month during which he or she attains age twenty-six (26). In the event a child:
 - i.) was defined as a "dependent", prior to age nineteen (19), and
 - ii.) meets the following disability criteria, prior to age nineteen (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 percent 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 nineteen (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 sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required. The plan requires periodic documentation from a physician after the child's attainment of the limiting age.

When completing your Open Enrollment, please make sure you carefully review the dependents listed on your summary. Enrolling dependents who are ineligible for medical, dental, or vision insurance will result in your dismissal from employment.

Additionally, if a dependent becomes ineligible for coverage during the year, you must notify the Indiana State Personnel Department's Benefits team within thirty days of the dependent becoming ineligible. **Maintaining coverage on dependents who become ineligible during the plan year may result in disciplinary action.**

Please Note: If you have questions or concerns about dependent coverage, or wish to enroll a dependent on your plans during Open Enrollment who is over age twenty six (26) and meets the definition of a disabled dependent but was not certified through Anthem, call the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007, if outside Indianapolis, to initiate the disabled dependent

certification process. **To be eligible to enroll your dependent(s) as part of your Open Enrollment event for an effective date of January 1, 2022, you must contact the Benefits Hotline during Open Enrollment and Anthem must certify that your dependent(s) meets the definition of a disabled dependent.**

Coverage

Dual coverage is not allowed under any benefit plan

Dual coverage of the same individual is not allowed under the state's health, 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.

Affordable Care Act: Section 6055 and 6056

In accordance with Section 6055 and 6056 of the Internal Revenue Code under the Affordable Care Act (ACA), the state is required to file health coverage information to the IRS by completing an information return along with furnishing statements to individuals who are or have been employed by the state during the year. The IRS will use the information gathered to determine if the employee was in compliance with the individual shared responsibility provision in section 5000A.

Under the ACA large employers, such as the State of Indiana, are required to request dependent social security numbers for use in completing IRS forms, 1094-C and 1095-C. Listed below are four methods in which you may report this information to the Benefits Division.

- **Phone:** 317-232-1167

(Indianapolis area), or 877-248-0007 (outside Indianapolis)

- **Fax:** 317-232-3011
- **Mail:** State Personnel Dept.
Attn: Benefits Division
402 W Washington St., W161
Indianapolis, IN 46204-2261
- **PeopleSoft Self Service:**
[Visit the PeopleSoft HR portal](#)
> Log in using your unique user ID and password > Click on Main Menu > Click Self Service > Click Benefits > Click Dependent/Beneficiary Info > Click Edit > Enter the SSN > Click Save > Sign out of PeopleSoft

All names and social security numbers in PeopleSoft must match the information listed on you and your dependents social security card. If you decide to report the information via phone, fax, or email, you must provide the Benefits Division with a copy of your social security card

along with your dependents. It is your responsibility to ensure that the correct information is in PeopleSoft for you and all of your dependents. If it is identified that PeopleSoft has an incorrect name or social security number on file for either you or one of your dependents, you will be required to provide documentation to the Indiana State Personnel Department's Benefits team to correct your record. Please note, if you do not provide your dependent's social security number the IRS may be unable to match the information you provide on your tax return. This may result in receiving an inquiry from the IRS or being liable for a shared responsibility payment.

If you have questions regarding this notice, please call the Benefits Hotline at 317-232-1167, or toll free at 877-248-0007, if outside Indianapolis.

Federal Notice

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Federal Notices

The Federal Notices listed below can be found at www.in.gov/spd/openrollment/federal-notices.

- Women's Health and Cancer Rights Act of 1998
- HIPAA Special Enrollment Rights Notice
- Creditable Coverage Notice
- HIPAA Notice of Privacy Practices
- Notice Regarding Wellness Program
- Nondiscrimination Notice
- Newborns' & Mothers' Health Protection Act of 1996
- Medicaid and the Children's Health Insurance Program (CHIP)
- USERRA (Military Leave) Notice
- Your Rights and Protections Against Surprise Medical Bills

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan or it's third-party administrator (Anthem Blue Cross Blue Shield). Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Out-of-network cost-shares (i.e., copayments, deductibles and/or coinsurance) will apply to your claim if the treating out-of-network provider determines you are stable, meaning you have been provided necessary emergency care such that your condition will not materially worsen and the out-of-network provider determines: (i) that you are able to travel to a network facility by non-emergency transport; (ii) the out-of-network provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the out-of-network provider after you are stabilized, you will be responsible for the out-of-network cost-shares, and the out-of-network provider will also be able to charge you any difference between the maximum allowable amount and the out-of-network provider's billed charges. This notice and consent

exception do not apply if the covered services furnished by an out-of-network provider result from unforeseen and urgent medical needs arising at the time of service.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Out-of-Network Services Provided at a Network Facility

When you receive covered services from an out-of-network provider at a network facility, your claims will be paid at the out-of-network benefit level if the out-of-network provider gives you proper notice of its charges, and you give written consent to such charges. This means you will be responsible for out-of-network cost-shares for those services and the out-of-network provider can also charge you any difference between the maximum allowable amount and the out-of-network provider's billed charges. This requirement does not apply to ancillary services. Ancillary services are one of the following services: (i) emergency services; (ii) anesthesiology; (iii) pathology; (iv) radiology; (v) neonatology; (vi) diagnostic services; (vii) assistant surgeons; (viii) Hospitalists; (ix) Intensivists; and (x) any services set out by the U.S. Department of Health & Human Services. In addition, Anthem Blue Cross Blue Shield will not apply this notice and consent process to you if Anthem Blue Cross Blue Shield does not have a network provider in your area who can perform the services you require.

Out-of-network providers satisfy the notice and consent requirement as follows: (i) by obtaining your written consent not later than 72 hours prior to the delivery of services; or (ii) if the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

Anthem Blue Cross Blue Shield is required to confirm the list of network providers in its provider directory every 90 days. If you can show that you received inaccurate information from Anthem Blue Cross Blue Shield that a provider was in-network on a particular claim, then you will be liable for in-network cost shares (i.e., copayments, deductibles, and/or coinsurance) for that claim. Your network cost-shares will be calculated based upon the maximum allowed amount. In addition to your network cost-shares, the out-of-network provider can also charge

you for the difference between the maximum allowed amount and their billed charges if the out-of-network provider has complied with balance billing laws.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Anthem Member Services at the phone number on the back of Your Identification Card or the United States Department of Labor (USDOL).

Visit www.anthem.com for more information about your rights under federal and state laws.