



The Torch

The official newsletter for State of Indiana employees

Open Enrollment Edition

2027

Open

Enrollment

It's time to
choose your
2027 benefits!

Oct. 28 – Nov. 18
by noon ET

Enroll online starting Oct. 28

This special edition of The Torch is dedicated to the 2027 Open Enrollment. Please review all the information concerning your health care coverage. During this period, from Oct. 28 to Nov. 18, you can choose to make additions or

changes to your benefit selections.

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

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

2026 RMBA Election Options

During the 2027 Open Enrollment period, certain active state employees, eligible for the Retirement Medical Benefits Account (RMBA), and hired before March 14, 2026, have the option to:

- Transfer their entire RMBA balance (contributions and earnings) to a newly created 2027 RMBA, or
- End their RMBA participation and receive a one-time, non-matching

employer contribution into their Hoosier START 401(a) account.

- The one-time contribution will be calculated based on their continuous years of service and age during each respective year and should be the equivalent of their RMBA contributions balance, minus earnings.

Learn more: www.in.gov/inprs/members/rmba

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

Benefit highlights for 2027

What is changing for 2027?

- **Deductibles, out-of-pocket maximums, and coinsurance:** Annual deductibles will increase across all medical plans and provider tiers. Annual out-of-pocket maximums will increase. Coinsurance rates will increase by 10%. Review the [2027 plan comparison](#) to understand the amounts that apply to your coverage and providers.
- **Spousal surcharge:** For employees subject to the surcharge, the amount will increase to \$125 per pay period. Before making your selections, review the surcharge requirements and any other employer-sponsored coverage available to your spouse.
 - The 2026 waiver will not carry over to 2027.
 - To apply for a waiver employees must submit the 2027 waiver via PeopleSoft by selecting Employee Self-Service → Benefit Details → Life Events → I want to fill out the Spousal Surcharge Waiver 2027.
- **Health Savings Account (HSA) contribution limits** are increasing to \$4,500 for single and \$9,000 for family. This is the maximum amount that can be contributed to an HSA and includes both employee and employer contributions.

What is staying the same?

- **Base medical premiums:** Employee premium rates for CDHP 1, CDHP 2 and the Traditional plan will remain at their 2026 levels, including rates with the non-tobacco discount.
- **State continues to invest in your benefits:** For eligible employees enrolled for the full year, the State's contributions toward medical coverage and applicable HSA funding total approximately \$9,752 for single coverage and \$27,832 for family coverage.
- **State HSA contributions:** Eligible employees enrolled in CDHP 1 can receive annual State contributions of up to \$1,124.76 for single coverage or \$2,249.52 for family coverage. For CDHP 2, those amounts are up to \$787.80 for single coverage or \$1,575.60 for family coverage. These funds can help pay for qualified expenses, including deductibles and prescriptions.
- **Non-Tobacco Use Agreement discount:** Eligible employees who complete the agreement and meet its requirements will continue to save \$35 per pay period on medical premiums—\$910 over a full year of 26 pay periods.
- **Dental and Vision Plans and costs** remain the same.
- **The prescription drug coverage plan:** All three plans will have prescription drug coverage through CVS Caremark and prescriptions are paid as Tier 1.
- **Flexible Spending Account administrative fee** will still be paid by the State.

2027

Open

Enrollment

Oct. 28 – Nov. 18

by noon (ET)

Open Enrollment for the 2027 plan year will take place from Oct. 28 through Nov. 18 at noon ET. This is your annual opportunity to review your benefits and make any updates to your healthcare coverage for the year ahead.

Subscribe to INSPD's communication channels to stay informed about 2027 Open Enrollment.

Publications:

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

Web: in.gov/spd/OpenEnrollment

When do 2027 Open Enrollment changes take effect?

Medical, dental, vision, life insurance, flexible spending account changes/enrollments:

- Effective: Jan. 1, 2027
- First deduction: Jan. 13, 2027

Direct bill agency employees - For deduction information, please see your agency's Payroll Department.

The 2027 Open Enrollment checklist

Is your current plan still the right plan for you? Now is the perfect time to review your options, look at your family's current health and finances, and choose the right coverage for you.

To make the election process easier, several resources are available to help you estimate your 2027 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, 2027.
- ☐ Access your HR PeopleSoft account. [View the quick step guide](#) for instructions about how to complete your Open Enrollment.
- ☐ Confirm or update personal info, including your home and/or mailing address, email address, and phone number.
- ☐ Confirm your Non-Tobacco Use Agreement. Your agreement will roll over from 2026. If you accept or continue to accept the agreement, you are agreeing to all the conditions of the Non-Tobacco Agreement for the 2027 plan year. **Note: You must accept or decline the Non-Tobacco Agreement to elect a medical plan.**
- ☐ If you cover a spouse on your medical insurance, **you must submit a new spousal waiver form for 2027 and receive approval to have the \$125.00 biweekly spousal surcharge waived. The 2026 waiver will not carry over to 2027.** Submit the waiver through PeopleSoft under Self-Service > Benefit Details > Life Events > I want to fill out the Spousal Surcharge Waiver 2027, and obtain approval before January 1, 2027, to receive the waiver on your first January paycheck.
- ☐ You must select the health savings account plan that matches the medical plan option you selected, or you will receive a warning message.
- ☐ **To cancel your insurance coverage, you must select "waive." As a reminder, if you waive your medical coverage, you must also waive your non-tobacco agreement and health savings account.**
- ☐ Review your eligible dependents and beneficiaries.
 - ☐ Enroll all eligible dependents in each benefit plan you choose.
 - ☐ Remove ineligible dependents from all your benefit plans and report their eligibility change to the Benefits Hotline.
- ☐ Enter personal information for new dependents and/or beneficiaries (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. Please do not add the dependent again.
- ☐ 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) and wish to contribute, 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 Benefit Reimbursement Account, your contribution will continue for 2027, unless you waive the coverage or change the contribution amount.
- ☐ Your benefit elections have been successfully submitted if the status under the Enrollment Summary page shows "Submitted."
- ☐ If your status under the Enrollment Summary shows "Changes saved – Submit to view," you need to select the Submit button as you have made changes since the last time you submitted your enrollment. These changes have been saved and submitted but will not be reflected on your Election Preview unless you select the Submit button.
- ☐ Be sure to print an **Election Preview** after you have submitted your elections.

If you have any questions regarding your benefits, please contact the INSPD Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007, Monday through Friday, 7:30 a.m. to 5 p.m. ET.

Health Plan Options

The State will continue offering three statewide medical plans for 2027: Consumer-Driven Health Plan 1 (CDHP 1), Consumer-Driven Health Plan 2 (CDHP 2), and Traditional Plan. All three plans are in the National (BlueCard) PPO network with Anthem and have a prescription drug plan through CVS Caremark. Each plan has differences in premium costs, deductibles, and out-of-pocket maximums. Below is a brief overview of the plans.

	CDHP 1			CDHP 2			Traditional		
	Tier 1 HealthSync	Tier 2 In-Network	Out of Network	Tier 1 HealthSync	Tier 2 In-Network	Out of Network	Tier 1 HealthSync	Tier 2 In-Network	Out of Network
Deductible									
Single	\$4,000	\$7,000	\$8,500	\$3,000	\$6,000	\$7,500	\$1,725	\$5,000	\$6,500
Family	\$8,000	\$14,000	\$17,000	\$6,000	\$12,000	\$15,000	\$3,450	\$10,000	\$13,000
Out-of-Pocket Maximum									
Single	\$6,000	\$8,700	\$10,500	\$5,000	\$8,000	\$9,500	\$4,000	\$7,000	\$8,500
Family	\$12,000	\$17,400	\$21,000	\$10,000	\$16,000	\$19,000	\$8,000	\$14,000	\$17,000

For more information about the cost of each plan, please review the [2027 rate chart](#).

This Open Enrollment, make sure you consider your anticipated health care needs when reviewing the three options. The amount you spend during the year is directly impacted by the plan you choose.

All three plans cover the same services and same providers but have different cost sharing when you get care or fill a prescription. Below is a brief overview of the plans to help you make an educated decision. All three plans will continue to offer two in-network tier options, giving you more ways to lower your costs.

Tier 1 - HealthSync: Lowest Cost Option: To save the most money, use providers within the

Tier 1 - HealthSync network. This tier has lower costs plus the lowest deductible, out-of-pocket maximum, and co-insurance rates. All in-network pharmacies through the prescription drug coverage are Tier 1 providers.

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.

The State's Health Savings Account (HSA) contribution amount to each plan will be the same as 2026. Below is an overview of the most you will pay under each plan if you reach your out-of-pocket maximum. Note: the chart assumes you take advantage of the Non-Tobacco Use Incentive, only used Tier 1 providers, are not subject to the spousal surcharge, and are eligible for an HSA. View the [Maximum Exposure Chart](#) for other scenarios.

[More about Health Plan Options](#)

With an HSA	Single			Family		
	CDHP 1	CDHP 2	Traditional	CDHP 1	CDHP 2	Traditional
Annual Employee Premium	\$859.56	\$1,237.08	\$2,756.52	\$2,608.32	\$3,995.16	\$9,466.08
Maximum Out-of-Pocket Cost	\$6,000	\$5,000	\$4,000	\$12,000	\$10,000	\$8,000
State Paid HSA Contribution	(\$1,124.76)	(\$787.80)	N/A	(\$2,249.52)	(\$1,575.60)	N/A
Total Exposure	\$5,734.80	\$5,449.28	\$6,756.52	\$12,358.80	\$12,419.56	\$17,466.08
Spousal Surcharge if applicable				\$3,250	\$3,250	\$3,250
Maximum Exposure	\$5,734.80	\$5,449.28	\$6,756.52	\$15,608.80	\$15,669.56	\$20,716.08

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.

90-day fills can be made at your local retail pharmacy or through mail order. You are not required to use a CVS pharmacy to fill prescriptions. You may use any in-network pharmacy.

Here are some ways you can save on your prescriptions:

- Check out CVS's Drug Cost and Coverage tool on the [CVS/Caremark website](#). All you have to do is create an account and use the Plan & Benefits tab to find the Check Drug Cost & Coverage tool. Use this tool to search for drugs to see plan coverage, generic alternatives

and cost at your pharmacy. This means that you're never caught off guard by the price of your medication at the counter again.

- Check programs like Good Rx and Mark Cuban Cost Plus Drugs for special deals. Because these programs focus on just a few medications, they can sometimes offer an even better deal than the already discounted pricing you get through your insurance. Check out [Good Rx](#) and [Mark Cuban Cost Plus Drugs](#) for more information.
- Check the drug manufacturer's website for discount programs. Manufacturer programs are usually for brand name medications. If you are able to take advantage of these low cost programs, you will have one extra step to take to make sure what you pay counts towards your deductible and out-of-pocket maximum.

When you use GoodRx or Mark



Cuban's Cost Plus Drugs, you are filling a prescription outside of your health plan. To make sure those expenses are counted toward your deductible, or to get reimbursed for what the plan would have covered, you must submit a Prescription Reimbursement Claim Form to CVS/Caremark. You can do this electronically by logging in at www.caremark.com and navigating to Plan & Benefits > Reimbursement Claims > Submit a New Claim.

Contact the INSPD Benefits Hotline if you have any questions, Monday through Friday, 7:30 a.m. to 5 p.m. ET. Call 317-232-1167 or toll-free at 877-248-0007 or email spdbenefits@spd.in.gov.

Take advantage of these benefits and start saving today!

[More about Prescription Coverage](#)

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 copay	\$20 copay	\$30 copay
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)		

Spousal Surcharge

A new waiver can help you avoid the surcharge in 2027. Employees covering a spouse under the State's health plan will pay a \$125 biweekly surcharge in 2027 unless a spousal surcharge waiver is submitted and approved. A new waiver is required for 2027, even if one was approved in 2026.

You may submit a Spousal Surcharge Waiver Request Form if any of the following apply to your spouse:

- Is not employed;
- Also works for the State;
- Works for a participating school corporation;
- Is not eligible for their employer's health plan; or
- Is eligible and enrolled in their employer's health plan.

Note: The surcharge will apply if you cover a spouse but do not complete these steps. Health care costs continue to rise, and the State must ensure that the State's health plan remains viable long-term for employees and their dependents.

How to complete the process:

- Complete the [2027 Spousal Surcharge Waiver Request Form](#). If your spouse is currently employed, their employer will need to complete the bottom section of the form.
- Once all required sections of the form are complete, log into [PeopleSoft self-service](#) and start a Benefit Life Event.
- Select *I want to fill out the Spousal Surcharge Waiver 2027*.

Complete the attestation, attach/upload your completed form within that life event.

- After you upload the form, INSPD Benefits will review your submission. Spousal Surcharge forms are answered in the order they are received. Due to the high volume of submissions, it may take 3 to 4 business days for your form to be processed.

Once INSPD is finished reviewing your submission, you will receive a workflow indicating if your form has been approved or denied. If denied, you will be responsible for paying the spousal surcharge. If approved, the spousal surcharge will be waived.

Note: The spousal surcharge is not part of the open enrollment process and will not appear in your premiums during open enrollment or in the benefits summary. If you know that you do not qualify for the waiver, you do not need to submit a Spousal Surcharge Waiver; the surcharge will be applied automatically.

Spousal Surcharge waiver deadline

To receive the waiver on the first paycheck in January, the 2027 Spousal Surcharge Waiver must be submitted and approved prior to January 1, 2027. The 2026 waiver will not carry over to 2027.

Spousal Surcharge Resources

- [2027 Waiver Request Form](#)
- [Flowchart Guide](#)
- [Quick-Step Guide](#)

More about the Spousal Surcharge

Eligibility for 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 37.5 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 eligible for medical, prescription, and HSA benefits only. Part-time and intermittent (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.

Open Enrollment quick links



[2027 Plan Rates](#)



[Health Plan Options](#)



[Health Savings Account](#)



[Life Insurance](#)



[Vision](#)



[Dental](#)

Anthem programs support your health goals



The State is committed to providing health plan members with helpful tools to achieve a more active and healthy lifestyle. All members enrolled in an Anthem plan receive special services at no additional cost.

Anthem 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, Weight Management, and more.

To start using the online tools, visit www.anthem.com, log in to your account, and select the "My Health Dashboard" tab at the top of the page and then "Programs" from the drop-down menu.

In addition to the online tools, representatives may contact you directly about one of the following programs.

Total Health Connections:

Gives you access to a team of clinicians to help you navigate any healthcare need. This team is here to help explain treatment options,

understand your care plan, connect with local resources, and guide you toward healthy lifestyle changes. The program can also connect you with specially trained nurses, nurse care managers, pharmacists, dietitians, doctors, and other health care professionals to help you manage conditions like diabetes, high blood pressure, asthma, and more. Call 877-814-9709 to connect with this program.

Building Healthy Families: 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.

Total Health Connections

Total Health Connections is an Anthem program designed to make healthcare simpler, more personal, and easier to navigate. With Total Health Connections, you'll have a Family Advocate by your side — your single point of contact. Whether you're managing a chronic condition, scheduling preventive care, or handling a health concern, your Family Advocate is here to help you and your family get the care you deserve. Total Health Connections is here to support you and your family every step of the way at no additional cost to you.

What your Family Advocate can do for you:

- Help you find top-quality, in-network doctors, specialists, and care facilities.
- Schedule appointments and stay on top of preventive care.

- Connect you with Anthem's clinical specialists for personalized care plans.
- Quickly secure approvals for urgent medical needs like surgery.
- Simplify your health plan and benefits, allowing you to focus on your well-being.

Get started:

Your Family Advocate is ready to help! Download or log in to Anthem's SydneySM Health app, available for [iPhone](#) and [Android](#). Log in using your Anthem User Name and Password from their web portal or register as a new user. Then, select More, and go to Care Team to send a message.

[View this flyer for details about how to get connected to the Sydney Health app.](#)

While you're in the app, you can also:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.



LiveHealth Online: See a doctor 24/7

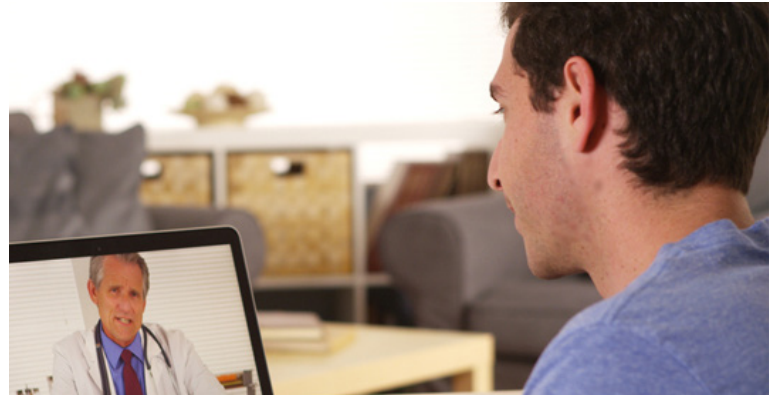
It's easier and faster than going to urgent care. The next time you or someone in your family needs to see a doctor, use LiveHealth Online. See a doctor with a smartphone or tablet using the free app, or a computer with a webcam.

With LiveHealth Online, you get:

- Immediate, 24/7 access to board-certified doctors.
- Secure and private video chats with your choice of doctor.
- Prescriptions that can be sent to your pharmacy, if needed.

Doctors on LiveHealth Online are available to diagnose and treat a wide variety of medical care

needs. See a doctor for these medical conditions/services and more: flu, cold & fever, psychology, minor rashes, sore throat, psychiatry, tooth pain, skin infections, allergy, pink-eye, headache, and diarrhea.



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

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

LiveHealth[®]
O N L I N E

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. 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.

Emotional Well-being Resources

Your emotional health is an important part of your overall health. With [Emotional Well-being Resources](#), administered by Learn to Live, you can receive support to help you and your household live your happiest, healthiest lives. Built on the proven principles of Cognitive Behavioral Therapy, their digital tools will be available anywhere.

They can help you identify thoughts and behavior patterns that affect your emotional well-being—and work through them. You'll learn effective ways to manage things like stress, depression, anxiety, substance use, panic, and sleep issues.

Emotional Well-being Resources provide a variety of tools:

- Personalized coaching
- Build a support team
- Practice mindfulness on the go
- Live and on-demand webinars

Access the program by logging into your account on Anthem.com or the Sydney app. Learn to Live is found in the Programs menu under Emotional Well-being Resources.

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? By choosing options other than the ER, your bill can be much lower and result in lower premiums for all employees. When seeking medical care, it is important that you consider all your options. However, it's important to

remember that 911 is your best resource for any potentially life-threatening emergency. Don't hesitate to call if you have concerning symptoms such as difficulty breathing or signs of a heart attack (chest pain or numbness, pain in arms, etc.).

Below is a quick look at the cost difference among alternative treatment facilities and examples on when to go to each. [Learn more about where to go for care.](#)

Every time you need care:



STOP



Review options



Save money

Where should you go to get care?

Options for care	Cost	Pros & Cons	Examples of When to Go
NurseLine	Free for members of Anthem Plan	Ease of access but may need follow up care for labs/other services.	Headaches, ear pain, allergies, questions regarding prescriptions, vaccines or more general health concerns.
LiveHealth Online	\$59	Ease of access but may need to seek follow up care for labs/other services.	Allergies, eye infection, sinus infection, UTI, rash, flu-like symptoms.
Retail Health Clinic	\$70	Ease of access but lacks health history that your PCP has & fewer care resources.	UTI, sore throat, STI testing, minor cuts and scrapes, ear pain, routine care like vaccines.
Primary Care Provider	\$105	Can take longer for an appointment but familiar with your health history.	Allergies, UTI, eye infection, sinus infection, rash, mild asthma, flu-like symptoms, aches/pains (not severe), routine care like vaccines.
Urgent Care	\$147	Typically no need for an appointment & often faster than ER visits.	UTI, ear/eye infections, sprains and strains, vomiting or diarrhea, sore throat, stitches.
Emergency Room	\$1,636	Doesn't require an appointment & has access to the most care resources.	Stroke, heart attack/chest pain, severe burns, difficulty breathing, uncontrolled bleeding, head injuries, etc.

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.

Dental plan:

In-network preventive services are 100% covered

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.



The dental plan covers diagnostic and preventive services, including cleanings, routine exams, and bitewing X-rays, at 100% if you

use an in-network provider. Other treatments such as fillings, crowns, and root canals are covered at 80% when you visit a network dentist. For the best savings, choose 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 logging onto www.Anthem.com. When logged in, select the “Find Care & Cost” link on the right side of the page. Add your address or zip code and search for “dentist.” Under “All Filters,” verify the Dental Network is selected under Plan Network.

To search without logging into your account, see the [Anthem How to Find Care - Dental Complete Flyer](#).

[More about the Dental Plan](#)

Vision plan

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.

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

Fixed Copay

Fixed Copays for premium progressive and anti-reflective lens are another way the State is

saving you money. 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.

Reviewing Benefit Eligibility

To view your current eligibility for an exam, frames, lenses, or contacts, follow these steps:

- Go to www.Anthem.com and log in to your account.
- Place cursor over the “My Plans” drop-down menu on top of the page.
- Select “Vision Benefits.”
- On the new page, select “View your vision benefit information” link.
- To view a dependent’s service eligibility, select the member on the drop-down menu.

- Select dependent and then “submit.”

Finding Care

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 and log in to your account. Once there, select the “Find Care & Cost” link on the right side of the page. Add your address or zip code and search for “optometrist.” Under “All Filters,” verify the “Vision Network” is selected for “Plan Network.”

[More about the Vision Plan](#)

State to contribute to Health Savings Account

The state will continue to contribute the same amounts to your HSA in 2027. The initial contribution will be made on your January 13, 2027, paycheck. Employees enrolled in a CDHP effective from January 1, 2027, through June 1, 2027, receive the full pre-fund amount. CDHPs effective after June 2, 2027, but before December 1, 2027, 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, 2027, or your first day of coverage in a state health plan during 2027.

If you have an active HSA with UMB and wish to continue receiving the state's contributions in 2027, you do not need to open a new HSA account.

Within PeopleSoft, Employee HSA contribution amounts do not carry over from year to year. If you would like to contribute to your account during 2027, you need to access your PeopleSoft record and

Plan	Initial Contribution	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

enter your desired contribution. If you are electing to participate in an HSA for the first time in 2027, you must select and elect the HSA option in PeopleSoft. UMB will automatically create your HSA account. You should receive the welcome letter prior to January 1. The welcome letter will contain your account number and information for enrolling in UMB HSA Online Banking. An HSA Debit card will arrive in a separate mailing approximately 7-10 business days after your account has been opened.

If additional information is required to open an HSA, a Request for Information Letter will be mailed. Please reply in a timely manner so the account can be opened quickly.

Resources for you:

- [Top questions about HSAs](#)
- [Saving and spending HSA dollars](#)
- [Healthy retirement plans include an HSA](#)
- [Pay for qualified medical expenses tax-free](#)

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).
- Can't be claimed as a dependent on another person's tax return.
- May not be enrolled in Medicare, Medicaid, HIP or Tricare.

View [IRS Publication 969](#) for more information.

HSAs have a maximum contribution limit

Contributions are allowed up to the maximum statutory limit. The maximum annual contribution for 2027 is \$4,500 for self-only policies and \$9,000 for family policies.

Individuals age 55 and over may make an additional catch-up contribution of up to \$1,000 in 2027.

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	\$4,500	\$1,124.76	\$3,375.24	\$129.81	\$4,375.24	\$168.27
HSA 1	Family	\$9,000	\$2,249.52	\$6,750.48	\$259.63	\$7,750.48	\$298.09
HSA 2	Single	\$4,500	\$787.80	\$3,712.20	\$142.77	\$4,712.20	\$181.23
HSA 2	Family	\$9,000	\$1,575.60	\$7,424.40	\$285.55	\$8,424.40	\$324.01

Health Savings Account (HSA) Disqualifications

Medicare, Medicaid, and HIP disqualify you from having an 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 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, 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.

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 an HSA, you should decline to receive Social Security retirement benefits and waive Medicare Part A. 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 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

According to IRS regulations, an individual who is enrolled in Medicaid or HIP 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 but you are not, you may continue to receive contributions to your HSA. Eligibility is based on the subscriber/ account holder.

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 for you. 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 \$325.

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 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, 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 if 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 to be reimbursed.

Eligible expenses are those you incur to commute to and from your place of employment. This

(Continued on pg. 13)

Continued: Commuter Benefit Reimbursement Account

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% 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 2026 will carry over to 2027, unless you waive your coverage.

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

Flexible Spending Accounts (FSA)

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 2027 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 an FSA for the 2027 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, 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 2026 account, you may continue to submit claims for reimbursed through ASIFlex until the grace period expires.

Medical Care & Limited Purpose FSA

Medical Care and Limited Purpose 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 2027, the annual contribution limit for the Medical Care and Limited Purpose FSAs will remain at \$3,300.

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 (\$1,750 for single and \$3,500 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 used to pay for dependent care services, such as preschool, summer day camp, before or after school programs and child or elder daycare. A qualifying individual is your dependent who is under the age of 13 (when services are incurred), or your spouse or an older dependent who is mentally or physically incapable of self-care who lives in your home at least 8 hours each day. Dependent care expenses do not include medical expenses and therefore can be used even if you participate in an HSA.

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. The maximum annual contribution amount for the Dependent Care FSA is increasing to \$7,500 (\$3,750 if married and filing separate tax returns).

For questions about FSAs, contact the INSPD Benefits Hotline at 317-232-1167 or 877-248-0007 (toll-free), or ASIFlex customer service 800-659-3035 or asi@asiflex.com.

More about FSAs

Non-Tobacco Use Incentive

The Non-Tobacco Use Incentive is being offered for the 2027 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 2027. Keep in mind, 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.

[Visit the FDA's website](#) for more info on FDA approved nicotine replacement therapy options.

Vaping and e-cigarette products are not FDA approved nicotine replacement therapy products.

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 2027. 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 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 your receipts for these products and/or copies of prescriptions from your physician to demonstrate your compliance with the NTUA.

Please note, your non-tobacco use agreement will roll-over. However, Open Enrollment is your opportunity to review the agreement and decide if you need to change your agreement status. If you accept or continue to accept the agreement, you are agreeing to all the conditions to the non-tobacco agreement for the 2027 plan year. If you waive your non-tobacco agreement without waiving your medical plan, you will receive an enrollment error. You must either accept or decline the non-tobacco agreement to enroll in a medical plan for 2027.

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.

[More about the NTUA](#)

Federal notices

The Federal Notices listed here can be found at www.in.gov/spd/openenrollment/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

Life insurance

Take some time during Open Enrollment to review your life insurance plans and beneficiaries. The State offers five types of coverage: Basic, Supplemental, Voluntary AD&D, Spouse Life, and Child Life Insurance. Take the time to review your finances and consider which option and coverage amount is best for you and your family.

Life election changes within Open Enrollment event

Within your Open Enrollment event you can make many changes to your plans without going through underwriting. These include:

- Electing Voluntary AD&D and Child Life Insurance (if you are currently enrolled in Basic Life

and AD&D insurance).

- Child Life Insurance may be elected in increments of \$5,000 up to and including \$20,000 for your child(ren).
- Decreasing your coverage level or dropping any of your life insurance plans.
- Updating your beneficiary information and/or allocation amounts.

Any updates you make to your life insurance within your Open Enrollment event will be effective January 1, 2027.

Life election changes outside of Open Enrollment event

If you wish to elect or increase your Basic Life and AD&D, Supplemental Life or Spouse

Dependent Life coverage, the process could not be easier. All you need to do is complete the online Evidence of Insurability (EOI) process at www.lifeBenefits.com/SubmitEOI.

On average the application only takes 10 to 30 minutes to complete. Once you submit your application Securian will review your information through underwriting and if approved, the Indiana State Personnel Department's Benefits division will automatically enroll you in the requested coverage.

[More about Life Insurance](#)

Review and 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 Indiana State Personnel'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 1, 2027.

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

Adult children may be covered under the State of Indiana's medical, dental, vision and child 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.

It is recommended that you access PeopleSoft during Open Enrollment to review or edit your dependent information. Keep in mind, you must 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 Marion County.

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 enroll your dependent in your plans with the effective date of January 1, 2027.

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, 2027.

Outside of Open Enrollment, you may only add a disabled dependent through a qualifying event. Like 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.

Please note: 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.

Qualifying events allow for changes

After noon (ET) on Wednesday, Nov. 18, 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).
- Changes to your spouse's

employment that impact the Spousal Surcharge.

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.

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.

"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;
 - i) for whom the employee or spouse has been:
 - I) appointed legal guardian or
 - II) awarded legal custody by a court, or
 - ii) in an I.C. 31-19-7-1 approved placement for purposes of adoption, under the age of twenty-six (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 Contractor in accordance with Contractor's disabled dependent certification and recertification

procedures. Eligibility for coverage of the "Dependent" will continue until the employee discontinues his coverage or the disability no longer exists. 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 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, carefully review the dependents listed on your summary. **Enrolling dependents who are ineligible for medical, dental, or vision insurance may 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 division within 30 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 26 and meets the definition of a disabled dependent call the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007.

To be eligible to enroll your dependent(s) as part of your Open Enrollment event for an

effective date of January 1, 2027, you must contact the Benefits Hotline during Open Enrollment and Anthem must certify that your dependent(s) meets the definition of a disabled dependent.

Dual coverage is not allowed under any health plan

State health, dental, and vision benefit plans prohibit dual coverage for the same person. For instance, you and your spouse both work for the State and have insurance (whether currently employed or retired), neither of you can cover each other on both plans or include the same children under family coverage. This policy applies even if the parents of the children are not married to each other. Each individual can choose a single plan, one can select family coverage while the other waives it, or one may carry family coverage with the children while the other has single coverage.

Another scenario involves a retiree who returns to active work in a different state position. In this case, you must choose between keeping your retiree coverage and waiving active employee coverage, or vice versa. You cannot hold both state retiree insurance and active employee coverage at the same time.

The only exception for dual coverage is for spouse and child life insurance.

Reporting Social Security Numbers

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 Affordable Care Act 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 here are five methods in which you may report this information to the Benefits Division.

- **Phone:** 317-232-1167 or 877-248-0007 (toll-free)
- **Fax:** 317-232-3011

- **Mail:** State Personnel Dept.
Attn: Benefits Division
402 W. Washington St., W161
Indianapolis, IN 46204-2261
- **Email:** SPDBenefits@spd.in.gov
Please send by encrypted email only.
- **PeopleSoft Self Service:**
[Visit the PeopleSoft HR portal](#)
> Log in using your unique user ID and password > Select the Nav Bar in the top right corner > Select Menu > Select Self Service from the drop-down menu > Select Benefits > Select Dependent/Beneficiary Info > Select the Name of the individual to update > 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 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 State Personnel Benefits 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 any questions regarding this notice, please contact the Benefits Hotline at 317-232-1167 or toll free at 877-248-0007 (if outside of Indianapolis). Additional information can be found on the [IRS website](#).

Important health coverage tax documents (1095-C forms)

The State no longer mails 1095-C tax forms. To receive a copy, you must request the form by calling SPD Benefits at 1-877-248-0007 or email 1095Requests@spd.IN.gov.

You can also mail the request to:

Indiana State Personnel Department
Benefits Division: 1095-C form request
402 West Washington St.
Room W161
Indianapolis, IN 46204

Include your first and last name, PeopleSoft ID and a phone number or email address where you can be reached. If you do not know your PeopleSoft ID, please provide the last 4 digits of your SSN. You may request the 1095-C form be e-mailed or mailed to your address on file in PeopleSoft.

Additional information may be requested prior to mailing or emailing the 1095-C form. **You do not need the 1095-C form to file**

your federal taxes.

Forms will be provided by January 31, 2027, or 30 days after the request; whichever is later.

More information can be found here: www.irs.gov/affordable-care-act/questions-and-answers-about-health-care-information-forms-for-individuals

Completing your Open Enrollment

You can access your Open Enrollment event 24 hours a day, seven days per week from Wednesday, October 28 through Wednesday, November 18 at noon (ET). You can access your Open Enrollment event from any computer that allows you access to

the internet. As a reminder, to sign into PeopleSoft, you must have [Multifactor Authentication \(MFA\)](#) set-up.

Quick Step Guide

- [2027 Open Enrollment Quick Step Guide](#)

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.

How to verify your Open Enrollment submission in PeopleSoft

Every Open Enrollment, the Benefits Hotline receives an influx of calls towards the end of Open Enrollment with employees inquiring if their elections have been successfully submitted. To save you time and stress, below is an overview of how you can verify if your elections were submitted in PeopleSoft.

Verification of Submission

1. **Navigate** to **Employee Self Service** from the homepage.
2. **Select** the **Open Enrollment** tile.
3. **Select** the **Benefits Enrollment** tab on the left side of the page.
4. If the **Status** under the **Enrollment Summary** shows **"Submitted,"** your elections have been saved.
5. **Navigate** to the **Benefits Statement** tab to **print** your **Elections Preview**.

If the **Status** under the **Enrollment Summary** shows **"Changes saved – Submit to view,"** you need to **select** the **Submit** button as you have made changes since the last time you submitted your enrollment.

- Once you **select** the **Submit** button the **Status** will change to **"Submitted."**
- **Navigate** to the **Benefits Statement** tab to **print** your new **Elections Preview**.

If the **Status** under the **Enrollment Summary** shows **"Pending Review,"** you need to **select** the **Submit** button to submit your elections.

- Once you **select** the **Submit** button the **Status** will change to **"Submitted."**
- **Navigate** to the **Benefits Statement** tab to **print** your new **Elections Preview**.

Potential Errors

If the **Submit** button is grayed out, there is an error in your enrollment that needs to be corrected.

- **Review** the benefit tile(s) under the **Benefits Enrollment** page to identify any tile(s) that show **"Error"** for the Status.
- **Select** the tile with the **"Error"** Status.
- **Read** the error message at the top of the page and **correct** the

corresponding issue.

- Once corrected, **select** the **Submit** button, and the **Status** will change to **"Submitted."**
- **Navigate** to the **Benefit Statement** tab to **print** your new **Elections Preview**.

If the **Benefits Alerts** pop up contains any warnings, there is an error in your enrollment that needs to be corrected.

- **Review** the warning. Then select the Done button.
- **Correct** the error associated with the warning message.
- Once corrected, **select** the **Submit** button the **Status** will change to **"Submitted."**
- **Navigate** to the **Benefits Statement** tab to **print** your new **Elections Preview**.

If you need additional assistance with completing your Open Enrollment, please view the [2027 Open Enrollment Quick Step Guide](#) and the [Verification of the Spousal Surcharge Waiver Request document](#), or call the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007.

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 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.

Employee Assistance Program (EAP) Eight free counseling sessions and more

We all understand the importance of taking care of our bodies. Eating well, exercising, and maintaining a healthy weight can make a big difference in our physical health and how we feel. Sometimes it's easy to forget that we need to care for our minds too. The [Optum Employee Assistance Program](#) (EAP) offers a wide variety of free services to you and your household members to help balance work and home life.

Full-time employees and their family members who reside in the household can connect with an Optum EAP consultant by phone at 800-886-9747, or online at <https://supportfinder.optum.com/Indiana> (sign in or register with an anonymous username).

The Optum EAP is a free, confidential service to help you

and your family navigate life's challenges.

Optum's team of experienced consultants is available by phone or online 24/7 to provide help with a range of life concerns and stressors, including:

- Relationship problems.
- Workplace conflicts and changes.
- Parenting and family issues.
- Stress, anxiety, and depression.
- Elder care support.
- Legal and financial concerns.

When you speak to a consultant, you'll receive immediate help or be directed to one of Optum's network providers. EAP provides up to eight (8) sessions with an experienced consultant for each issue or problem at no cost to

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you, and the benefit renews each calendar year. All conversations are confidential, and they never share your personal records with your employer or anyone else without your permission.

Connect with Optum EAP



Call for personal support
800-886-9747



Log in supportfinder.optum.com/Indiana (sign in or register with an anonymous username)

More about Optum EAP