
CALL THE BENEFITS HOTLINE WITH QUESTIONS MONDAY – FRIDAY, 7:30AM – 5:00PM EST
Indianapolis area 317-232-1167
Outside Indianapolis 1-877-248-0007 (Toll-Free)

Or email us at: SPDBenefits@SPD.IN.gov

Webinars will be available to learn more about your 2017 benefit options.

DEADLINE IS WEDNESDAY, NOVEMBER 9 BY 4:00 p.m. EST

@INSPDBenefits
www.IN.gov/SPD/openenrollment
2017 Benefits Overview

On, October 19, 2016 we will begin the annual open enrollment for health benefits in 2017. This is your annual opportunity to explore the many well-being options the State of Indiana has to offer you and your eligible family members. I hope this open enrollment period raises your awareness of the programs and opportunities you have at your disposal to improve your overall health and well-being. We are so pleased and encouraged by this participation and the engagement in our Invest in Your Health sponsored programs during 2016! Your enthusiasm and feedback in HumanaVitality and improving overall well-being continues to motivate us to deliver comprehensive benefits that help you meet your personal health goals.

In 2017, our healthcare costs are expected to increase $15 million. More significantly, new specialty drugs that offer real solutions to some of our members come with much higher costs for 2017. The good news — overall health improvement trends are starting to make a difference. This will allow us to pass along a smaller increase than in previous years. Thankfully, the hard work that our employees are putting in to improve their health and seek the most efficient care possible has helped to slow the rate at which our costs are increasing. We continue to gain momentum by making smarter choices, as more employees engage in our wellness initiatives and commit to making healthy changes in the lives of their families. This is extremely encouraging!

HumanaVitality is now in its second year with the state. This wellness portal allows employees to improve their overall wellbeing by understanding their current wellbeing level, set goals and track their progress on those goals. More than 7,750 employees, a marked improvement over 2015, have taken advantage of this wellness tool and attained Silver Status in HumanaVitality by August 31, which qualifies them to enroll in the Wellness CDHP. While the savings in both bi-weekly premiums and additional HSA contributions are meaningful, even more so are the participants’ positive changes in lifestyle that have made them feel better and more aware of their health risks.

The Wellness CDHP upgrade offers participants meaningful savings (Continued on page 3)
over the CDHP 1 and 2 plans and also offers higher HSA contributions. Wellness CDHP qualifiers have earned $1,048 in premium savings and an additional $500 in HSA contributions for those with family coverage. All Silver Status achievers should be notified by letter about their ability to select the Wellness CDHP Plan.

Another valuable Invest in Your Health program is Castlight. This cost and quality transparency tool enables our members to be better consumers. Making good consumer choices means better health outcomes and lower costs for you.

Understanding all of your open enrollment options can be overwhelming. To ease understanding, here are three simple steps you can take now to evaluate the best options for you and your family in 2017:

1. Visit www.in.gov/spd/openenrollment to review your plan options.
2. Visit www.InvestInYourHealthIndiana.com to see all of the resources the State of Indiana offers you to be proactive in managing your health. This includes a “Checklist as You Go” template to guide you through a successful 2017 Open Enrollment.
3. Ensure you are getting all the information SPD provides to make your open enrollment successful. Ensure your personal information is updated in PeopleSoft and follow our @INSPDBenefits Twitter feed to obtain the latest and greatest health plan updates.

Open enrollment begins Wednesday, October 19 and ends at 4 p.m. (EST), Wednesday, November 9, 2016. First and foremost — stay informed. Carefully read the Open Enrollment communication, study the options, discuss the decisions with your spouse if you carry family coverage and take advantage of the resources available to you. The decisions you make during Open Enrollment impact you and your family for the next year.

The highlights of the 2017 benefits include:

- Four healthcare plans (three CDHPs and one Traditional PPO)
- Family Out-of-Pocket-Limits (OOPM) are now $7,150 in the CDHP1 and Wellness CDHP Plans for individual limits
- Non-tobacco use incentive remains at $35 per pay period
- The Medical Flexible Spending Account contribution limit remains at $2,500
- Those who qualify for the Wellness CDHP, the state will contribute approximately 50 percent of the deductible into an HSA on an annual basis.
  - HSA — $1,251.12 (single); $2,502.24 (family)
- For CDHP 1 and CDHP 2 participants with an HSA, the state will contribute nearly 40 percent of the deductible on an annual basis.
  - HSA1 — $1,001.52 (single); $2,003.04 (family)
  - HSA2 — $599.04 (single); $1,198.08 (family)

Educate yourself about changes occurring Jan. 1, 2017.
Maximum personal costs calculations*

<table>
<thead>
<tr>
<th>Single Coverage</th>
<th>Wellness CDHP</th>
<th>CDHP1</th>
<th>CDHP2</th>
<th>Traditional PPO</th>
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<td>($599.04)</td>
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<table>
<thead>
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<th>Family Coverage</th>
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<th>Traditional PPO</th>
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<td>State’s HSA contribution</td>
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<td>($2,003.04)</td>
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<tr>
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*Examples assume employee is participating in the non-tobacco use incentive, using in-network providers and has an open HSA account. These comparisons represent the worst case scenario, which would include the premium costs, deductible and maximum out-of-pocket expenses for 2017.

What is next?

Start now, before open enrollment launches, to learn all you can about the options and your needs.

1. Review your health expenses from this year and begin projecting next year’s expenses. Log onto www.anthem.com and review your up-to-date medical claims. If you have not registered with Anthem online, you will need to do that before you have access. Participants can also log on to Castlight to view a summary of year-to-date spending.

2. Log onto Express Script’s website and look at your pharmaceutical claims (www.expressscripts.com). From there, you will have a fairly good idea of what your expenses have been and should be able to make an estimate for 2017.

3. Read and analyze all the information available to you and attend webinars, carrier fairs, and information sessions – in order to become a well-informed healthcare consumer. If you plan to take advantage of the meetings or webinars, make sure you first get your supervisor’s approval. These events are usually allowed on state time.

4. Ask questions if you don’t understand. Call or email the Benefits Hotline to talk with a benefits specialist.

Questions?

More detailed information is available on the 2017 Open Enrollment website: www.in.gov/spd/openenrollment/

Or, contact the Benefits Hotline toll-free at 1-877-248-0007 outside of Indianapolis or 317-232-1167 within the Indianapolis area. Benefit specialists are available from 7:30 a.m. to 5 p.m. Monday through Friday, Eastern Standard Time.

You may also email your questions to SPDBenefits@spd.in.gov.
A guide to a successful Open Enrollment

Completing your Open Enrollment

You can access your Open Enrollment event 24 hours, seven days a week from Wednesday, Oct. 19 through 4:00 p.m. Wednesday, Nov. 9 (EST). Keep in mind, you can access your Open Enrollment event from any computer that allows access to the internet.

Helpful hints:

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

IMPORTANT: Once you are satisfied with your open enrollment elections, it is essential that you submit your elections and print a Benefit Election Summary for your records.

Remember, you can access PeopleSoft at any time during the year to review your benefits or update contact information. You may access PeopleSoft through any of the below links:

- https://hr.gmis.in.gov/psp/hrprd/?cmd=login&languageCd=ENG&
- http://www.in.gov/spd and click on the PeopleSoft HR link on the right side
- http://myshare.in.gov/ and select the Oracle Human Resources link.

To view your current benefit elections, you need to login to PeopleSoft and follow these steps: Click on Self Service, Click on Benefits and Click on Benefit Summary. Your 2017 benefits will not be available to view until Jan. 1, 2017.

If you have questions about your elections, contact the Benefits Hotline, 7:30 a.m. to 5 p.m. (EST) Monday through Friday. Call 317-232-1167 within Indianapolis area or 1-877-248-0007 toll-free outside Indianapolis.

2017 BENEFITS OPEN ENROLLMENT

When do my changes take effect?

Health, dental, vision, Health Savings Accounts and Flexible Spending Accounts change / enrollments will be effective January 1, 2017.

Deductions for health, dental and vision will begin:

- **Payroll A**: Dec. 28, 2016 (14 days at new plans & rates)
- **Payroll B**: Dec. 21, 2016 (7 days at old plans & rates; 7 days at new plans & rates)

Deductions for the Flexible Spending Accounts and Health Savings Accounts will begin on the following dates:

- **Payroll A**: Jan. 11, 2017
- **Payroll B**: Jan. 4, 2017

Effective dates for Life insurance changes / enrollments will vary depending on which payroll you are in along with the date your deductions will begin.

- **Payroll A**:
  - Effective: Jan. 1, 2017
  - Deduction: Dec. 28, 2016
- **Payroll B**:
  - Effective: Jan. 8, 2017
  - Deduction: Jan. 4, 2017
- **Direct Bill**:
  - Effective: Jan. 1, 2017
Non-Tobacco Use Incentive

The Non-Tobacco Use Incentive is being offered again for the 2017 plan year. You can receive a $35 reduction in your group health insurance bi-weekly premium by accepting the agreement during Open Enrollment. By accepting the incentive, you are agreeing to not use any form of tobacco products in 2017. This applies to employees who have never used tobacco products, employees who have refrained from using tobacco products in past years and to those employees who have decided to quit using tobacco products prior to Jan. 1, 2017. Keep in mind, by accepting the agreement you are agreeing to be subject to testing for nicotine at any time during the year. The Non-Tobacco Use Agreement must be completed each year online.

The Non-Tobacco Use Incentive is only available to employees who have enrolled in medical coverage. You will not have access to the agreement if you waive medical coverage for plan year 2017. The reduction in your group health insurance bi-weekly premium only applies to your employee medical premium, and does not apply to your dental, vision or life insurance premiums.

If you accept the Non-Tobacco Use Agreement during Open Enrollment and later use tobacco, your employment will be terminated. The only exception to the job loss penalty is if you revoke the agreement 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 will walk you through it. If you revoke the agreement you will be 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.

The Non-Tobacco Use Incentive does not carry over from year-to-year. If you would like to participate in 2017 you must access your PeopleSoft record and accept the agreement. Notice: If your physician determines abstaining from the use of tobacco is not medically appropriate, a reasonable alternative standard will be made available for the incentive.

2017 BENEFITS OPEN ENROLLMENT

Need help?

For 2017 plan summaries, rates, PeopleSoft instructions and other Open Enrollment information, please log onto www.in.gov/spd/openenrollment. Help sessions are provided in Indiana Government Center South Training Room 31 throughout Open Enrollment for those needing assistance with entering elections and navigating through PeopleSoft. Hours are (Eastern Standard Time):

- Oct. 19 to Oct. 21: 8 a.m. to 12 p.m.
- Oct. 24 to Oct 28: 12 p.m. to 4 p.m.
- Oct. 31 to Nov. 7: 9 a.m. to 3 p.m.
- Wednesday, Nov. 9: 9 a.m. to 4 p.m.

If you have specific questions about Open Enrollment not answered on the State Personnel Department’s website, call or email a Benefits Specialist in State Personnel:

PHONE:
(317) 232-1167 (within Indianapolis)
Toll free 1-877-248-0007 (outside the 317 area code)

EMAIL:
SPDBenefits@spd.in.gov
Summary of Plans and Rates
State offers four different options for single and family coverage

The State of Indiana is again offering four statewide medical plans for 2017: Wellness Consumer-Driven Health Plan (Wellness CDHP), Consumer-Driven Health Plan 1 (CDHP1), Consumer-Driven Health Plan 2 (CDHP2) and Traditional Preferred Provider Organization (PPO). All four available plans are in the National BlueCard® PPO network with Anthem and have a prescription drug plan through Express Scripts. Each plan has differences in premium costs, deductibles and out-of-pocket maximums.

Please note in order to be eligible to enroll in the 2017 Wellness CDHP you must have reached an Earned Status of Silver in HumanaVitality by August 31, 2016. This means all points must have been processed and posted to your HumanaVitality account by the August 31 deadline. If you qualified for the Wellness CDHP and wish to enroll in the plan for 2017, you must select this option within your Open Enrollment event. You will not be automatically enrolled in the plan unless you were enrolled in the Wellness Plan for the 2016 plan year. If you were enrolled in the 2016 Wellness CDHP but did not qualify for the 2017 Wellness CDHP your coverage will automatically be switched to the CDHP 1, unless you actively elect another plan.

Here are the differences at a glance:

<table>
<thead>
<tr>
<th>Feature</th>
<th>Wellness CDHP</th>
<th>CDHP 1</th>
<th>CDHP 2</th>
<th>Traditional PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
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<td></td>
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<td></td>
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<tr>
<td>Single</td>
<td>$2,500</td>
<td>$2,500</td>
<td>$1,500</td>
<td>$750 / $1,500</td>
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<td>$5,000</td>
<td>$3,000</td>
<td>$1,500 / $3,000</td>
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<tr>
<td><strong>Out-of-pocket maximum</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$3,000</td>
<td>$3,000 / $6,000</td>
</tr>
<tr>
<td>Family</td>
<td>$8,000</td>
<td>$8,000</td>
<td>$6,000</td>
<td>$6,000 / $12,000</td>
</tr>
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<td>- Individual Embedded</td>
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<td>$7,150</td>
<td>Not applicable</td>
<td>Not applicable</td>
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<tr>
<td><strong>Co-insurance</strong></td>
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<td></td>
<td></td>
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<tr>
<td>In-Network</td>
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<td>20%</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>50%</td>
</tr>
</tbody>
</table>

All three of the Consumer-Driven Health Plans (CDHPs) have the same prescription coverage while the Traditional PPO has slightly higher copays, coinsurance rates and min/max amounts.

Family Out-of-Pocket Change for Wellness CDHP and CDHP 1

The individual embedded out-of-pocket maximum for the family Wellness CDHP and CDHP 1 will change this year from $6,850 to $7,150. The individual embedded out-of-pocket maximum saves families money by limiting the cost spent on anyone person to $7,150. Once a family member meets the individual embedded out-of-pocket maximum all claims incurred by that family member will be 100% paid by the plan. The other family members on the plan will continue to pay the coinsurance amounts for any claims they occur until the family out-of-pocket maximum of $8,000 is obtained.
# Summary of Plans and Rates

## State of Indiana 2016 Rates

<table>
<thead>
<tr>
<th>Plan</th>
<th>Coverage</th>
<th>Bi-Weekly Employee Rate</th>
<th>Bi-Weekly Total Rate</th>
<th>Early Retirees (Monthly)</th>
<th>COBRA (Monthly)</th>
<th>Annual Employer Rate</th>
<th>Annual Employer HSA Contribution</th>
<th>Total Annual Employer Contribution</th>
<th>Annual Total Rate</th>
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<td>$17.08</td>
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**Flexible Spending Accounts**

| Medical, Limited Purpose Medical (HSA Holders) and/or Dependent Care Admin Fee | $0.00 | $1.62 | $1.62 | $3.51 | $3.51 | $0.00 | $42.12 | $42.12 |

*Initial contribution as listed above apply to employees with a CDHP effective between 1/1/17 through 6/1/17 and with an open HSA. CDHPs effective after 6/1/17 but before 12/1/17 and with an open HSA, will receive 1/2 of the initial contribution.

*Employees participating in the CDHP plans are reminded that they must open an HSA account in order to receive the state’s HSA contribution.*
Wellness Program

HumanaVitality becomes Go365 in 2017

HumanaVitality will soon be Go365 as of January 1, 2017. We can also expect some exciting innovations in tandem with HumanaVitality’s name change to Go365. The important thing to remember is the key components we saw in HumanaVitality will remain in Go365; you’ll still receive Points, Bucks and rewards for working on your health and well-being!

What you can expect on day one of Go365:
- An elevated member experience
- Improved Points and Bucks structure
- Increased member control
- More fun!

We’ll describe what each of these changes mean and how it will impact your experience (for the better) as we get closer to 2017. In the meantime, don’t stop what you’re doing already with HumanaVitality. Continue earning those Vitality Points™ and reaching for a higher Vitality Status™!

Not a member? Sign up today at our.humana.com/investinyourhealth/.

See a preview of Go365 at www.go365.com/preview

2018 Wellness CDHP qualification

The State of Indiana is again offering a way to upgrade your health plan during Open Enrollment next fall. Similar to this year, the Wellness Consumer Driven Health Plan (CDHP) offers lower premiums to those who qualify.


Castlight

Castlight helps you spend your healthcare dollars wisely

Castlight gives you the information you need to make smart health care decisions for you and your family. Using Castlight online or through the mobile app, you can:

- Compare nearby doctors, medical facilities, and health care services based on the price you’ll pay and quality of care.

- See personalized cost estimates based on your location, your health plan, and whether or not you’ve already paid your deductible.

- Price compare brand name and generic prescriptions.

- Find the closest pharmacy and estimate how much you’ll pay for a prescription.

- Review step-by-step explanations of past medical spending so you know how much you paid and why.

Castlight lists prices for doctors and services that have been used by State employees. Although all medical services may not have prices, the most common ones will, and new prices are added every month. Essentially, the service lets all State employees share the costs of their medical services in a completely anonymous and private way. In this way, employees can help each other lower medical costs for themselves and the State of Indiana. Click here to read more information about Castlight.

Get started with Castlight today! Register at https://mycastlight.com/stateofindiana.

Read the Notice Regarding Wellness Program on page 43.
Wellness Program

Employee Assistance Program (EAP)

EAP offers a wide variety of free services to you and your dependents and/or household members to help balance work and home life. One of the newest services available is **three face-to-face counseling sessions**, per issue with a licensed therapist. Access to this benefit is as easy as picking up the phone and calling 800-223-7723.

When you call, you want to select option one, EASY program, from the prompt menu. Once you are connected with an EAP representative, ask them about therapy visits. The representative is trained to assist you in finding a therapist that fits your needs and guide you through the process of scheduling your first appointment. For your convenience, appointments can even be scheduled within LiveHealth. If you are interested in this option, please let the representative know.

All services can be accessed privately and are confidential. Below is a quick look at some of the other services available through EAP.

- **Assistance with legal and financial concerns**, including a 30-minute initial consultation, per issue, with a qualified attorney or financial advisor.
- **Dependent care referrals**. Locate child and eldercare providers using online tools or calling your EAP directly.
- **Convenience services**. Obtain resources and information on pet sitters, educational choices for you or your children, summer camp programs and much more.
- **Website** – [www.anthem.EAP.com](http://www.anthem.EAP.com). Contains a comprehensive level of resource articles, self-assessments, audio and video material covering emotional well-being, health and wellness, the workplace, and life issues such as childcare, eldercare, adoption and education.
- **Smoking cessation**. Access telephonic tobacco cessation coaching for smoking and chewing, coaching support with weight management as it relates to the cessation program, 10-session online Living Free behavior change module and tobacco cessation tip sheets.
- **ID recovery and credit monitoring**. Assess your risk level and identify steps to resolve potential identity theft. Your EAP can help you complete any necessary paperwork, report to consumer credit agencies for you, and negotiate with creditors to repair your debt history.

To access Anthem’s EAP online resources, visit their **website**. Once on their homepage, click the “Members Login” button on the left side of the page. On the next page enter your company name, which is State of Indiana. Once you hit the “Log In” button, all of these services are open to you. There is free 24-hour, seven days per week phone access at 800-223-7723 for immediate support.

**LiveHealth Online**

The State of Indiana is excited to offer online health benefits through LiveHealth. Seeing a doctor has never been so convenient. Through LiveHealth, 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 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 you choose. The average cost of a doctor visit using LiveHealth is $49 or less.

Not only can you be seen by a medical doctor, you can also receive psychology services through LiveHealth. The psychology services can even be used in coordination with the three 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.

- Call EAP at **800-232-7723** and select option one, EASY Program.
- Answer some general information, such as your name, date of birth and address.
- Ask the EAP representative about therapy visits.
- The EAP representative provides you with a (continued on page 44)
# Health plans for 2017

## Wellness CDHP At A Glance

## Your Anthem Benefits

### State of Indiana - Wellness Consumer-Driven Health Plan

**National BlueCard PPO**

**Summary of Benefits, Effective January 1, 2017**

**Please note:** As we receive additional guidance and clarification on federal health care reform from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

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<thead>
<tr>
<th>Covered Benefits</th>
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<td><strong>Deductible</strong></td>
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<td>Single: $2,500</td>
</tr>
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<td><strong>Out-of-Pocket Limit (OOP) (Single/Family)</strong></td>
<td>Family coverage requires the family OOP to be met before 100% coverage applies. The single OOP does not apply to family coverage. Out-of-Pockets are combined network and non-network; includes the deductible</td>
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<td></td>
<td>20%</td>
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<tr>
<td>• diabetic education (regardless of outpatient setting)</td>
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<td></td>
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<tr>
<td>• MRAs, MRIs, PETs, C-scans, nuclear cardiology imaging studies and non-maternity related ultrasounds</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td>No deductible/coinsurance</td>
<td>40% (not subject to deductible)</td>
</tr>
<tr>
<td>Services include but are not limited to:</td>
<td></td>
<td></td>
</tr>
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<td>Annual physical exams, pelvic exams, pap testing, PSA tests, immunizations, annual diabetic eye exam, routine vision and hearing screenings. Vision screening limited to basic screening in PCP office.</td>
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<td></td>
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<tr>
<td>All preventive services are limited to one of each service per year per covered member; if the office visit is billed separately or if the primary purpose of the office visit is not for the delivery of a preventive service, cost sharing may be imposed for the office visit</td>
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<td></td>
</tr>
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<td><strong>Emergency and Urgent Care</strong></td>
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<td></td>
</tr>
<tr>
<td>• Emergency Room services at hospital (facility/other covered services)</td>
<td>20%</td>
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<td>• Urgent Care Center services</td>
<td>20%</td>
<td>20%</td>
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<td><strong>Maternity Services</strong></td>
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<td>20%</td>
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<td><strong>Inpatient and Outpatient Professional Services</strong></td>
<td>include but are not limited to:</td>
<td>20%</td>
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<td>• Medical care visits, intensive medical care, concurrent care, consultations, surgery and administration of general anesthesia and newborn exams</td>
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<tr>
<td><strong>Inpatient Facility Services</strong></td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td><strong>Outpatient Surgery Hospital/Alternative Care Facility</strong></td>
<td>Surgery and administration of general anesthesia</td>
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</tr>
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<td><strong>Other Outpatient Services (including but not limited to):</strong></td>
<td></td>
<td></td>
</tr>
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<td></td>
<td>20%</td>
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<td>• Home care services (network/non-network combined) Unlimited visits (includes IV therapy) (No RN/LPN unless billed through a home health care agency)</td>
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<td></td>
</tr>
<tr>
<td>• Durable medical equipment and orthotics (network/non-network combined) Unlimited benefit maximum (including medical supplies)</td>
<td></td>
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<td>• Prosthetic devices unlimited benefit maximum for prosthetics received on an outpatient basis. (Surgical prosthetics do not apply)</td>
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<td>• Physical medicine therapy/day rehabilitation programs</td>
<td></td>
<td></td>
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<tr>
<td>• Hospice care</td>
<td></td>
<td>20%</td>
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</tbody>
</table>
### Covered Benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
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<tbody>
<tr>
<td>Outpatient Therapy Services (Combined network and non-network limits apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician Home and Office Visits (PCP/SCP)</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Other outpatient services at hospitals/alternative care facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical therapy; 25 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Occupational therapy; 25 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Manipulation therapy; 12 visits</td>
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<td></td>
</tr>
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<td>• Speech therapy; 25 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health and Substance Abuse(^1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient facility services (Residential MHSA covered as inpatient)</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Physician home and office visits (PCP/SCP)</td>
<td></td>
<td></td>
</tr>
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</tr>
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<td>Authorization of all inpatient and outpatient psychiatric and substance abuse</td>
<td></td>
<td></td>
</tr>
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<td>allowed.</td>
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### Prescription Drug Coverage – THIS COVERAGE IS ADMINISTERED BY EXPRESS SCRIPTS\(^3\)

Below benefits apply after medical deductible has been met; prescription expenses accumulate to the OOP maximum

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<td>20% - minimum $30, maximum $50</td>
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<td>40% - minimum $50, maximum $70</td>
<td>40% - minimum $100, maximum $140</td>
</tr>
<tr>
<td>Specialty</td>
<td>40% - minimum $75, maximum $150</td>
<td></td>
</tr>
<tr>
<td>Preventive (mandated by the ACA)</td>
<td>$0</td>
<td>(no deductible)</td>
</tr>
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</table>

**Notes:**

- Non-network human organ and tissue transplants are excluded from the out-of-pocket limits.
- Dependents: Age of the child attains age 26.
- No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a non-network provider, the member is responsible for any balance due after the plan payment.
- Benefit Period: calendar year.
- Private Duty Nursing – limited to 82 visits Calendar Year and 164 visits/lifetime.
- Skilled Nursing Facility – limited to 100 days.

\(^1\)We encourage you to contact our mental health subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.

\(^2\)Kidney and cornea are treated like any other illness and subject to the medical benefits.

\(^3\)PRESCRIPTION BENEFITS ADMINISTERED BY EXPRESS SCRIPTS. ANY QUESTIONS RELATED TO RX NEED TO BE DIRECTED TO (877)841-5241

**Precertification:**

- Members are encouraged to obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.
Health plans for 2017
CDHP 1 At A Glance

Your Anthem Benefits

State of Indiana - Consumer-Driven Health Plan 1
National BlueCard PPO Network
Summary of Benefits, Effective January 1, 2017

Please note: As we receive additional guidance and clarification on federal health care reform from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

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# Health plans for 2017

## CDHP 1 At A Glance

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| **Outpatient Therapy Services**<br>(Combined network and non-network limits apply)<br>  
  - Physician Home and Office Visits (PCP/SCP)<br>  
  - Other outpatient services at hospital/alternative care facility<br>  
  - Physical therapy: 25 visits<br>  
  - Occupational therapy: 25 visits<br>  
  - Manipulation therapy: 12 visits<br>  
  - Speech therapy: 25 visits | 20%     | 40%         |
| **Behavioral Health Services:**<br>**Mental Health and Substance Abuse**<br>  
  - Inpatient facility services<br>  
  - Physician home and office visits (PCP/SCP)<br>  
  - Other outpatient services at hospital/alternative care facility<br>  
  Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained, benefits will not be allowed. | 20%     | 40%         |
| **Human Organ and Tissue Transplants**<br>  
  - Acquisition and transplant procedures, harvest and storage | 20%     | 40%         |

### Prescription Drug Coverage – THIS COVERAGE IS ADMINISTERED BY EXPRESS SCRIPTS<sup>3</sup>

Below benefits apply after medical deductible has been met; prescription expenses accumulate to the OOP maximum.

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<tr>
<td><strong>Brand Non-Formulary</strong></td>
<td>40% - minimum $50, maximum $70</td>
<td>40% - minimum $100, maximum $140</td>
</tr>
<tr>
<td><strong>Specialty</strong></td>
<td>40% - minimum $175, maximum $150</td>
<td>(30-day supply only)</td>
</tr>
<tr>
<td><strong>Preventive Rx</strong></td>
<td>$0</td>
<td>(no deductible)</td>
</tr>
</tbody>
</table>

**Notes:**

- Non-network human organ and tissue transplants are excluded from the out-of-pocket limits.
- Dependent Age: to end of the month in which the child attains age 26
- No copayment/copayment means no deductible/copayment/copayment to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a non-network provider, the member is responsible for any balance due after the plan payment.
- Benefit Period = calendar year.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Skilled Nursing Facility – limited to 100 days.

<sup>1</sup>We encourage you to contact our mental health subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.

<sup>2</sup>Kidney and corneas are treated the same as any other illness and subject to the medical benefits.

<sup>3</sup>PRESCRIPTION BENEFITS ADMINISTERED BY EXPRESS SCRIPTS. ANY QUESTIONS RELATED TO RX NEED TO BE DIRECTED TO (877)841-5241

**Preauthorization:**

- Members are encouraged to always obtain prior approval when using non-network providers. Preauthorization will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.
# Health plans for 2017

## CDHP 2 At A Glance

### Your Anthem Benefits

**State of Indiana - Consumer-Driven Health Plan 2**

**National BlueCard PPO Network**

**Summary of Benefits, Effective January 1, 2017**

*Please note:* As we receive additional guidance and clarification on federal health care reform from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

<table>
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<tr>
<th>Covered Benefits</th>
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<tbody>
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<td><strong>Deductible</strong></td>
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<td></td>
</tr>
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<td></td>
</tr>
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<td></td>
</tr>
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</tr>
<tr>
<td>40%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Surgery Hospital/Alternative Care Facility</strong></td>
<td></td>
<td></td>
</tr>
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</tbody>
</table>
Health plans for 2017
CDHP 2 At A Glance

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Therapy Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Combined network and non-network limits apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician Home and Office Visits (PCP/SCP)</td>
<td>20%</td>
<td>40%</td>
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<td>• Physical therapy: 25 visits</td>
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</tr>
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</tr>
</tbody>
</table>

| Behavioral Health Services:                           |         |             |
| Mental Health and Substance Abuse¹                    |         |             |
| • Inpatient facility services                         |         |             |
| • Physician home and office visits (PCP/SCP)         | 20%     | 40%         |
| • Other outpatient services at hospital/alternative care facility | 20%     | 40%         |

Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained, benefits will not be allowed.

| Human Organ and Tissue Transplants²                  |         |             |
| • Acquisition and transplant procedures, harvest and storage | 20%     | 40%         |

Prescription Drug Coverage – THIS COVERAGE IS ADMINISTERED BY EXPRESS SCRIPTS³

Below benefits apply after medical deductible has been met; prescription expenses accumulate to the OOP maximum

<table>
<thead>
<tr>
<th></th>
<th>Retail Rx (Up to a 30-day supply)</th>
<th>Mail Order Rx (Up to a 90-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic</strong></td>
<td>$10 co-pay</td>
<td>$20 co-pay</td>
</tr>
<tr>
<td><strong>Formulary</strong></td>
<td>20% - minimum $30, maximum $50</td>
<td>20% - minimum $60, maximum $100</td>
</tr>
<tr>
<td><strong>Brand Non-Formulary</strong></td>
<td>40% - minimum $50, maximum $70</td>
<td>40% - minimum $100, maximum $140</td>
</tr>
<tr>
<td><strong>Specialty</strong></td>
<td>40% - minimum $75, maximum $150 (30 day supply only)</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive</strong></td>
<td>(mandated by the ACA)</td>
<td>$0</td>
</tr>
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</table>

Notes:
- Non-network human organ and tissue transplants are excluded from the out-of-pocket limits.
- Dependent Age: to end of the month in which the child attains age 26.
- For copayment/co-insurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a non-network provider, the member is responsible for any balance due after the plan payment.
- Benefit Period = calendar year.
- Private Duty Nursing – limited to 82 visits Calendar Year and 164 visits/lifetime.
- Skilled Nursing Facility – limited to 100 days.

¹We encourage you to contact our mental health subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.

²Kidney and cornea are treated the same as any other illness and subject to the medical benefits.

³PRESCRIPTION BENEFITS ADMINISTERED BY EXPRESS SCRIPTS. ANY QUESTIONS RELATED TO RX NEED TO BE DIRECTED TO (877)841-5241

Pre-certification:
- Members are encouraged to always obtain prior approval when using non-network providers. Pre-certification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

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# Health plans for 2017

## Traditional PPO At A Glance

### Your Anthem Benefits

**State of Indiana - Traditional PPO**  
**National BlueCard PPO Network**  
**Summary of Benefits, Effective January 1, 2017**

**Please note:** As we receive additional guidance and clarification on federal health care reform from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

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<td><strong>Deductible</strong></td>
<td>Single $750</td>
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<td>Family $1,500</td>
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<td><strong>Out-of-Pocket Limit (OOP) (Single/Family)</strong></td>
<td>Single $3,000</td>
<td>Single $6,000</td>
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<tr>
<td>Family coverage requires the family OOP to be met before 100% coverage applies.</td>
<td>Family $6,000</td>
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<td>30%</td>
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<td>• Ambulance services</td>
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# Health plans for 2017

## Traditional PPO At A Glance

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</tr>
</thead>
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<tr>
<td>Generic Retail Rx (Up to a 30-day supply)</td>
<td>$20 co-pay</td>
<td>$40 co-pay</td>
</tr>
<tr>
<td>Formulary</td>
<td>30% minimum $40, maximum $80</td>
<td>30% minimum $80, maximum $120</td>
</tr>
<tr>
<td>Brand Non-Formulary</td>
<td>50% minimum $50, maximum $90</td>
<td>50% minimum $140, maximum $180</td>
</tr>
<tr>
<td>Specialty</td>
<td>50% minimum $100, maximum $175 (30 day supply only)</td>
<td></td>
</tr>
<tr>
<td>Preventive (mandated by the ACA)</td>
<td>$0</td>
<td>(no deductible)</td>
</tr>
</tbody>
</table>

**Notes:**
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- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
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1Kidney and cornea are treated the same as any other illness and subject to the medical benefits
1PRESCRIPTION BENEFITS ADMINISTERED BY EXPRESS SCRIPTS. ANY QUESTIONS RELATED TO RX NEED TO BE DIRECTED TO 877-841-5241

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Health Savings Accounts (HSA)

State continues to contribute to Health Savings Account

The state continues to contribute 40 percent or more of the Consumer-Driven Health Plan (CDHP) annual deductible to your Health Savings Account (HSA) in 2017, depending on what plan you choose. The initial contribution is made on the first check in January. Employees enrolled in a CDHP effective from January 1, 2017 through June 1, 2017 receive the full pre-fund amount. CDHPs effective after June 2, 2017, but before December 2, 2017, 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, 2017.

If you have an active HSA with The HSA Authority at Old National Bank and wish to continue receiving the state’s contributions in 2017, you do not need to open a new HSA account with The HSA Authority.

If you wish to change your contribution to your account or begin contributing for 2017, you need to access your PeopleSoft record and enter your desired contribution. If you do not change your HSA contribution, it does not carry over for the 2017 plan year.

### State contribution to health savings accounts in 2017

<table>
<thead>
<tr>
<th>HSA Account</th>
<th>Coverage</th>
<th>Initial Contribution</th>
<th>Bi-Weekly Contribution</th>
<th>Monthly Contribution</th>
<th>Maximum Annual ER Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSA w/ Wellness CDHP 1</td>
<td>Single Family</td>
<td>$625.56</td>
<td>$24.06</td>
<td>$52.13</td>
<td>$1,251.12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$1251.12</td>
<td>$48.12</td>
<td>$104.26</td>
<td>$2,502.24</td>
</tr>
<tr>
<td>HSA 1 w/ CDHP 1</td>
<td>Single Family</td>
<td>$500.76</td>
<td>$19.26</td>
<td>$41.73</td>
<td>$1,001.52</td>
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<tr>
<td></td>
<td></td>
<td>$1,001.52</td>
<td>$38.52</td>
<td>$83.46</td>
<td>$2,003.04</td>
</tr>
<tr>
<td>HSA 2 w/ CDHP 2</td>
<td>Single Family</td>
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<td>$23.04</td>
<td>$49.92</td>
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</tr>
</tbody>
</table>

As a 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;
- May not be enrolled in Medicare, Medicaid, HIP or Tricare;
- Must not have used VA benefits for anything other than preventative services in the past three months.

To open your HSA, link to The HSA Authority’s website from PeopleSoft on your HSA election page, or go directly to www.theHSAuthority.com and click on the “Enroll Now” 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” and it will begin the state application.

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

1. Driver’s license
2. Social Security number, date of birth and address for your beneficiaries
3. Social Security number, date of birth and address for your authorized signer (if selected)
4. Security passwords for you and your authorized signer (based on the answer to one of the five questions you select during the application process)
HSA Basics
A health savings account (HSA) is a tax-advantaged checking account that gives you the ability to save for future medical expenses or pay current ones. It is individually owned; however, you may elect to designate an authorized signer who may also withdraw funds and be issued a debit card.

HSA Eligibility
To be eligible to make deposits to 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;
• May not be enrolled in Medicare, Medicaid, or Tricare;
• Must not have used VA medical benefits in the past three months, with the exception of preventative services or treatment for a service-connected disability.

Contributions to your HSA
The annual maximum allowable contributions to an HSA, as established by the IRS, for 2017 are:
• Individual: $3,400
• Family: $6,750
Individuals 55 and older can make an additional catch-up contribution of $1,000 in 2017. A married couple can make two catch-up contributions if both spouses are eligible. The spouses must deposit the catch-up contributions into separate accounts. The annual maximum contribution is based on a calendar year and there is no limit to the dollar balance that can build in the account over time. Contributions can come from:
• Employee pre-tax payroll withholding
• Employer contributions (non-taxable income)
• Individual contributions from account owner or other individual (tax-deductible for account holder)
• IRA or Roth IRA rollover

Distributions from your HSA
• You, or an authorized signer, can make withdrawals (or distributions) for qualified expenses.
• Distributions from your HSA can be made by check, debit card, ATM, online bill payment or by in-person request.
• Distributions for qualified medical expenses are tax free.
• Distributions made for anything other than qualified medical expenses are subject to IRS tax plus a 20% penalty. The penalty is waived if the account owner is 65 or older, or due to death or disability.
• Qualified medical expenses for your spouse and your tax dependents’ may be paid from your HSA, even if those individuals are not covered under your consumer-driven health plan (CDHP).
• You’re responsible for keeping receipts for all distributions from your HSA. The bank does not monitor how the funds are spent.

Advantages of an HSA
Portability:
You can take 100% of the deposited funds with you when you retire or change employers. You are the account owner.
Flexibility:
You can choose whether to spend the money on current medical expenses or you can save your money for future use. Unused funds remain in the account from year to year and there is no “use it or lose it” provision.
Tax Savings:
• Contributions are tax free, (pre-tax through payroll deductions or tax deductible)
• Earnings are tax free
• Funds withdrawn for eligible medical expenses are tax free.
Premium Savings:
An HSA-qualified insurance plan tends to be less expensive than a traditional insurance plan.
Allowable Expenses

To be a qualified medical expense, the expense has to be primarily for the diagnosis, cure, mitigation, treatment or prevention of disease. It must be to alleviate or prevent a physical or mental defect or illness. These expenses may or may not apply to your insurance deductible depending on the coverage provided by your medical plan.

Vision and dental expenses, such as glasses, contact lenses, eye exams, dental cleanings and orthodontia are all allowable expenses from your HSA. Medical supplies such as Band-Aids, crutches, test strips and even contact solution are allowable as well.

Insurance premiums only under the following circumstances: while receiving federal or state unemployment benefits, COBRA premiums, qualified long-term care insurance premiums and Medicare and other health care premiums after age 65 (with the exception of Medicare supplement policies such as Medigap).

Examples of Allowable Expenses:

- Acupuncture
- Alcoholism Treatment
- Ambulance
- Bandages
- Birth Control Pills
- Breast Reconstruction
- Car Hand Controls (for disability)
- Chiropractors
- Christian Science Practitioners
- Contact Lenses
- Crutches
- Dental Treatment
- Dermatologist
- Diagnostic Devices
- Disabled Dependent Care Expenses
- Drug Addiction Treatment (inpatient)
- Eyeglasses
- Fertility Enhancement
- Guide Dog
- Gynecologist
- Hearing Aids
- Home Care
- Hospital Services
- Laboratory Fees
- LASIK Surgery
- Lodging (for out-patient treatment)
- Long-Term Care
- Meals (associated with receiving treatments)
- Medicare Deductibles
- Nursing Care
- Nursing Homes
- Obstetrician
- Operations
- Ophthalmologist
- Optician
- Optometrist
- Osteopathic Treatment
- Organ Transplant (including donor’s expenses)
- Orthodontia
- Orthopedist
- Over-the-Counter Medications (if prescribed)
- Oxygen and Equipment
- Pediatrician
- Personal Care Services (chronically ill)
- Podiatrist
- Prenatal Care
- Prescription Drugs
- Prescription Medicines
- Prosthesis
- Psychiatric Care
- Qualified Long-Term Care Services
- Smoking Cessation Programs
- Surgeon/Surgical Room Costs
- Therapy
- Transportation Expenses for Health Care Treatment
- Vaccines
- Vitamins (if prescribed)
- Weight Loss Programs (certain expenses if diagnosed by physician)
- Wheelchair
- Wig (for hair loss from disease)
- X-Rays

Non-Allowable Expenses

Insurance premiums are not eligible expenses (exceptions listed above).

Costs associated with non-medically necessary treatments are not eligible. This includes cosmetic surgery and items meant to improve one’s general health (but which are not due to a specific injury, illness or disease) such as health club dues, gym memberships, vitamins and nutritional supplements.

Over-the-counter medications are not eligible unless you obtain a prescription from a doctor. The prescription is not required for purchase; however, retain it for your records in the event it is required by the IRS.

Examples of Non-Allowable Expenses:

- Advance Payment for Future Medical Expenses
- Automobile Insurance Premium
- Baby-sitting (healthy children)
- Commuting Expenses for the Disabled
- Controlled Substances
- Cosmetics and Hygiene Products
- Diaper Service
- Domestic Help
- Electrolysis (hair removal)
- Funeral Expenses
- Hair Transplant
- Health Club and Gym Memberships
- Household Help
- Illegal Operations and Treatments
- Illegally Procured Drugs
- Maternity Clothes
- Non-Prescription Medicines (as of January 1, 2011)
- Nutritional Supplements
- Premiums for Accident Insurance
- Premiums for HSA Qualified Health Plan (prior to age 65)
- Premiums for Life or Disability Insurance
- Scientology Counseling
- Teeth Whitening
- Travel for General Health Improvement
- Tuition in a Particular School for Problem

For a complete list or further information, please refer to IRS Publication 502 and Publication 969 at www.irs.gov. These rules are subject to change.
HSAs at Tax Time

- You’ll receive Form 1099 SA for your distribution total and Form 5498 SA for your contribution total for the previous year. These figures are reported to the IRS and you are required to report them on IRS Form 8889 when filing your federal taxes. See IRS Publication 969 or consult your tax advisor for further information.
- You may make contributions to your HSA for the previous calendar year up to the tax filing deadline, which is normally April 15th. If you make prior year deposits, you will receive an updated Form 5498 SA in May with your complete contribution total to keep with your tax records.

Prior Year Deposits: Prior year contributions should be clearly communicated to bank personnel. If mailing a deposit, be sure to note it is for the prior year. Deposits made at an ATM machine, remote deposit using your mobile phone, electronic transfers made using any method or those that are not specifically communicated to bank personnel will automatically be processed as a current year contribution.

Insurance Coverage Changes

- If you start an HSA-qualified health plan mid-year, you may contribute the full annual maximum to your HSA. However, a testing rule applies to those that start a CDHP any time other than January 1st. Per the IRS, you must remain an HSA-eligible individual through December 31st of the next calendar year. If you’re not sure you’ll remain on the plan, you may want to pro-rate your contribution amount in order to avoid having the excess added to your gross income and an additional 10% tax on that amount.
- If your insurance coverage changes from individual to family mid-year, you’re eligible for the full family contribution limit for that calendar year.
- If your insurance coverage changes from family to individual mid-year, your contribution limit will need to be pro-rated according to how many months you were on each type of insurance coverage.

What If...

You receive a medical bill or are paying for a prescription at the pharmacy and you want to use funds from your HSA.

Pay using your HSA debit card, HSA checks or through online bill pay.

You’re at the pharmacy and realize you don’t have your HSA debit card, checks, or you don’t have enough funds in your Health Savings Account.

Pay for the purchase with personal funds and later you may reimburse yourself using one of the “HSA Reimbursement Options” listed below.

You’re faced with a medical emergency and do not have enough in your HSA to cover your portion of the hospital bill.

Option 1 – Ask provider to set up a payment plan. As funds are deposited into your HSA you can make payments to the provider using your HSA debit card, online bill pay or checks.

Option 2 - Pay with another personal checking account, savings account or credit card. Then reimburse yourself as funds accumulate in your HSA. Many providers will agree to offer a discount for paying the bill in full.

You’re required to pay for treatment at the time of service. Later you receive a reimbursement check from the provider.

Option 1 - Cash the check and pay for other eligible medical expenses and save those receipts.

Option 2 - Mail the check to Old National Bank for deposit to your HSA noting it is a reimbursement deposit.

You purchase groceries and a prescription. How should you handle the transaction?

Option 1 - Pay for the groceries separately and use your HSA debit card or checks for the prescription only.

Option 2 - Pay for everything with non-HSA funds and later reimburse yourself for the medical portion.

Foreign ATM fees may apply

HSA Reimbursement Options

(apply yourself back for qualified medical expenses paid with non-HSA funds):

1) Use free Online Bill Pay to request a check be sent to you.

2) Use free Online Account to Account Transfer to transfer funds between accounts at other financial institutions and your HSA.

3) Write an HSA check to yourself.

4) Visit an Old National Bank Branch or ATM to make a withdrawal. There is no fee for withdrawals at an ONB Branch or ATM. See our Branch / ATM locator feature at www.theHSAauthority.com.¹

5) Complete and submit a Withdrawal Authorization Form found under the Forms tab at www.theHSAauthority.com.

¹Foreign ATM fees may apply
Opening Your HSA Online

You’ll need the following information when you begin:

- Unexpired government issued ID for the account holder and for an authorized signer, if elected. This can be a driver's license, state-issued ID, passport, or military ID.
- The date of birth for your beneficiaries.
- The social security number and date of birth for the authorized signer, if elected.

Complete the following steps to open your account:

1. Go to theHSAauthority.com and click on the “Enroll Now” button. Click on “Continue” to access the account opening website.

2. Select the option “If you have been instructed by your employer...” The prompt to enter your six-digit employer code will appear. Enter the code that was provided by your employer. If you are not with an employer group, select “All others click here.”

3. Click the “Continue” button at the bottom of the screen to continue the account opening process.

4. Once you have successfully submitted your enrollment application, a confirmation number will appear.

5. After completing the online enrollment, you’ll receive a welcome letter in the mail with your new HSA information.

6. If you requested a debit card it will be mailed separately and will arrive following the welcome letter. If checks are requested, the order is held and processed after your balance reaches $25.00.

Online Banking & eStatements

Your Welcome Letter contains your new HSA number along with instructions for accessing Old National Bank’s online banking site and telephone banking system. If you choose eStatements, be sure to follow the instructions in the welcome letter to activate your eStatement election. If you’d like assistance using these services, please call our Client Care Center toll-free at 888-472-8697.
Website Features
Visit theHSAauthority.com for helpful tools!

HSA Calculators
Employees can easily compare a high-deductible health plan with an HSA to a traditional health plan and calculate the future value of their HSA.

Health Information Links
Informational websites for individuals to compare important hospital quality data and gather reliable information on diseases, health conditions and wellness issues.

HSA Resources
- Retail pharmacy discount programs and their websites to help locate the best price possible
- Healthcare and prescription drug cost-saving strategies to assist in finding and negotiating the best price
- An expense tracking sheet is available to help start tracking eligible medical expenses.

Medtipster
Locate affordable generic drug programs available across the country with many drugs costing as little as $4. If a medication is available at a discount, a list of pharmacies in the area is presented along with pricing. As an added value, Medtipster also offers area flu shot, immunization, and health screening searches.

Forms and Address Changes
Easily access forms to make changes to your HSA on our website. Click on the Forms tab at the top of the page to access forms such as our: Address Change Form, Additional Authorized Signer Form, Beneficiary Change Form, Name Change Form, plus many others. The completed form can be mailed to us for processing.

Online Messages and Address Changes
When signed in to Online Banking, you can quickly and easily request an address change, send a message or request information from our Client Care team.

Contact Us
Contact Client Care at 888-472-8697, or send an email to info@theHSAauthority.com for more information.
<table>
<thead>
<tr>
<th><strong>Product Features</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enrollment Fee</strong></td>
<td>Free online enrollment</td>
</tr>
<tr>
<td><strong>Minimum Opening Balance</strong></td>
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<tr>
<td><strong>Annual Fee</strong></td>
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</tr>
<tr>
<td><strong>Service Charge</strong></td>
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<tr>
<td><strong>Statement Options</strong></td>
<td>Online or paper statements available</td>
</tr>
<tr>
<td><strong>Interest Rates</strong></td>
<td>Interest rates may vary based on account balance; rates subject to change; refer to our website for information or call our Client Care Center</td>
</tr>
<tr>
<td><strong>Annual IRS Reporting and Updates</strong></td>
<td>5498-SA (contributions), 1099-SA (distributions), and adjustments for prior year contributions</td>
</tr>
<tr>
<td><strong>24/7 Automated Telephone Banking</strong></td>
<td>Toll-free number 1-800-731-2265</td>
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<tr>
<td><strong>Deposit Processing</strong></td>
<td>Automatic deposit, mail in service, or in-person at any Old National location</td>
</tr>
<tr>
<td><strong>Online Banking</strong></td>
<td>Free access to view statements, account activity, balance, and front and back of paid checks</td>
</tr>
<tr>
<td><strong>Online Account to Account Transfer</strong></td>
<td>Free access to transfer funds between accounts at other financial institutions and your HSA</td>
</tr>
<tr>
<td><strong>Online Bill Pay</strong></td>
<td>Free access to pay bills online through online banking</td>
</tr>
<tr>
<td><strong>Debit Card</strong></td>
<td>Free debit cards for account owner and authorized signer</td>
</tr>
<tr>
<td><strong>ATM Access</strong></td>
<td>Free ATM withdrawals at any Old National ATM; fees will apply for ATM withdrawals at non-Old National ATMs; refer to bank fee schedule</td>
</tr>
<tr>
<td><strong>Check Fees</strong></td>
<td>No per-check fees; see website for current printing fee per order of 30 checks</td>
</tr>
<tr>
<td><strong>Certificate of Deposit Options</strong></td>
<td>Available; call Client Care at 1-888-472-8697, option 2 for current rates and terms; FDIC insured</td>
</tr>
<tr>
<td><strong>Investment Options</strong></td>
<td>Available; call Client Care at 1-888-472-8697, option 2 for more information; $36 Annual Fee</td>
</tr>
<tr>
<td><strong>Bank Service fees</strong> (overdraft, stop pay, etc.)</td>
<td>Call Client Care at 1-888-472-8697, option 1 for details</td>
</tr>
</tbody>
</table>

For account opening instructions, see insert or visit our website at theHSAauthority.com.

**Address:** The HSA Authority, HSA Operations, PO Box 3606, Evansville, IN 47735

**Email:** info@theHSAauthority.com

**Phone:** 888-472-8697, Monday through Friday 8am-8pm and Saturday 8am – 3pm ET

*Please consult your insurance advisor about available plan options.*
Health Savings Accounts (HSA)

HSAs have a maximum contribution limit

Contributions are allowed up to the maximum statutory limit. The maximum annual contribution for 2017 is $3,400 for self-only policies and $6,750 for family policies. Individuals age 55 and over may make an additional catch up contribution of up to $1,000 in 2017. Combined household contributions cannot exceed the family limit. The maximum includes the state’s contributions and any other contributions to your HSA.

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

The IRS established Health Savings Accounts 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. 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;
- May not be enrolled in Medicare, Medicaid, HIP or Tricare;
- Must not have used VA benefits for anything other than preventative services in the past three months.

Based on the above eligibility qualifications, enrolling in Medicare, Medicaid or HIP 2.0 will disqualify you from having contributions into a Health Savings Account (HSA). Once enrolled in any of these plans, you may not receive or make any contributions into a HSA. For more information about HSAs please see IRS Publication 969 at http://www.irs.gov/pub/irs-pdf/p969.pdf.

Although you can no longer make contributions to your HSA once you are covered by Medicare, Medicaid or HIP 2.0 the money that has accumulated in your HSA from past years remains yours to spend, tax-free, on eligible expenses, including Medicare co-pays 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 the below information carefully as it relates to your eligibility to qualify for an HSA.

Medicare

If you elect to receive Social Security Benefits, you will automatically be enrolled in Medicare Part A when you turn age 65. If you wish to participate in the HSA, you should decline to receive Social Security retirement benefits and waive Medicare Part A. Keep in mind that 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 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 the 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 into 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 into your HSA. Eligibility is based on the subscriber/account holder.
**Flexible Spending Accounts (FSA)**

**FSAs can provide tax-free help for qualified medical expenses with no administration fee this year**

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’s dedicated for the reimbursement of qualified medical, vision and dental expenses. In addition, the bi-weekly employee administration fee is being paid by the state during the 2017 plan year, providing you with even more opportunities to save.

There are three types of FSAs: Medical Care, Limited Purpose and Dependent Care. All of the state’s FSA programs are administered through Key Benefits Administrators and 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.

You must re-enroll in medical and dependent care FSAs each year if you wish to continue to participate. If you continue participation, do not discard the debit card from Key Benefit Administrators. New cards are not automatically issued each year.

**Medical Care and 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 2017, the maximum annual contribution for the Medical Care and Limited Purpose FSAs is $2,500.

A Limited Purpose FSA may only be used for dental, vision and preventive care expenses until the minimum deductible of a CDHP is met ($1,300 for single and $2,600 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 Consumer Driven Health Plan with a Health Savings Account, your FSA will automatically become 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. Dependent care expenses do not include medical expenses and therefore can be used even if you participate in a HSA.

Dependent Care FSAs are not front-loaded. 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).
Prescription drug benefits

Express Scripts provides more than just prescriptions

Pharmacy benefits for all state health plans are provided by Express Scripts. All three of the Consumer-Driven Health Plans (CDHPs) have the same prescription coverage while the Traditional PPO has slightly higher copays, coinsurance rates and min/max amounts.

Express Scripts’ website (www.express-scripts.com) offers several cost-and time-saving features. For instance, you can review the claims that have been submitted for your 2016 prescriptions to help you make an informed decision about your 2017 election. Then, take it a step further, and shop for the lowest price on your medications. Enter the name of your prescription and the website lists the price and any generics or other options for treatment of your particular condition. This helps you to make informed investments of your healthcare dollars.

Keep in mind that in addition to retail pharmacies, you can utilize Express Scripts mail order pharmacy. They offer a 90-day supply on some medications. After you meet your deductible, you can purchase a 90-day supply for the cost of 60 days. That could provide you quite a savings. Armed with the costs of your medications, that information could help you better calculate your prescription costs for 2017.

Express Scripts also has specialty pharmacists, available around the clock, who can answer your questions about cardiovascular, diabetes, cancer, women’s health, neuroscience and pulmonary conditions.

Learn more about Express Scripts by visiting www.express-scripts.com or call, toll free 1-877-841-5241.

<table>
<thead>
<tr>
<th></th>
<th>Wellness CDHP</th>
<th>CDHP 1</th>
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<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
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</tr>
<tr>
<td>- Individual Embedded</td>
<td>$7,150</td>
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<td>not applicable</td>
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</tr>
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</table>

State of Indiana Rx Benefit Comparison

Copay/co-insurance after deductible is met and before out-of-pocket maximum is satisfied (applies to all four plans: Wellness CDHP, CDHP 1, CDHP 2 and Traditional PPO).

<table>
<thead>
<tr>
<th>Prescription drugs</th>
<th>Wellness CDHP</th>
<th>CDHP 1</th>
<th>CDHP 2</th>
<th>Traditional PPO</th>
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<tbody>
<tr>
<td>Preventive (mandated by the ACA)</td>
<td>Retail (30 day supply)</td>
<td>Mail (90 day supply)</td>
<td>Retail (30 day supply)</td>
<td>Mail (90 day supply)</td>
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<tr>
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<td>$0 no deductible</td>
<td>$0 no deductible</td>
<td>$0 no deductible</td>
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<tr>
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<td>$10 copay</td>
<td>$20 copay</td>
<td>$10 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Brand, Formulary</td>
<td>20% Min $30, Max $50</td>
<td>20% Min $30, Max $50</td>
<td>20% Min $30, Max $50</td>
<td>20% Min $30, Max $50</td>
</tr>
<tr>
<td>Brand, Non-formulary</td>
<td>40% Min $50, Max $70</td>
<td>40% Min $50, Max $70</td>
<td>40% Min $50, Max $70</td>
<td>40% Min $50, Max $70</td>
</tr>
<tr>
<td>Specialty</td>
<td>40% Min $75, Max $150 (30 day supply)</td>
<td>40% Min $75, Max $150 (30 day supply)</td>
<td>40% Min $75, Max $150 (30 day supply)</td>
<td>50% Min $100, Max $175 (30 day supply)</td>
</tr>
</tbody>
</table>
Dental Coverage

No changes coming to the state’s Dental plan during 2017

Good dental health may be more important than you think. Studies identify a link between oral health and chronic conditions such as heart disease. Lower your risk by keeping up with 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 medical 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.

<table>
<thead>
<tr>
<th>Dental</th>
<th>2017 Bi-Weekly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$1.32</td>
</tr>
<tr>
<td>Family</td>
<td>$3.42</td>
</tr>
</tbody>
</table>

Vision Coverage

Anthem remains vision provider for 2017

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 only costs you $10 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, you can save money on contacts and frames if needed. The plan allows for frames every 24 months and contact lenses every 12 months. When purchasing these items, you pay nothing unless you exceed the $110 frame or $105 contact allowance provided under the plan when using an in-network provider.

Through Anthem Blue View Vision, you and your dependents have a large network of ophthalmologists, optometrists, opticians and retail locations to choose from. Look for providers in the Select network.

<table>
<thead>
<tr>
<th>Dental</th>
<th>2017 Bi-Weekly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$0.17</td>
</tr>
<tr>
<td>Family</td>
<td>$2.52</td>
</tr>
</tbody>
</table>

The Anthem Dental Complete and the Anthem Blue View Vision Plan Summaries follow on the next five pages.
WELCOME TO YOUR DENTAL PLAN!
This benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your employee benefits booklet.

Dental coverage you can count on
Your Anthem dental plan lets you visit any licensed dentist or specialist you want – with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits – you get more for your money.
You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

<table>
<thead>
<tr>
<th>YOUR DENTAL PLAN AT A GLANCE</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Benefit (Maximum – (Calendar Year)</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Annual Maximum Carryover</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Orthodontic Lifetime Benefit Maximum</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td>Annual Deductible – (Calendar Year)</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td></td>
<td>$150 family maximum</td>
<td>$150 family maximum</td>
</tr>
<tr>
<td>Deductible Waived for Diagnostic &amp; Preventive Services and Orthodontic Services</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Dental Services

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic and Preventive Services</strong></td>
<td><strong>Anthem Pays:</strong></td>
</tr>
<tr>
<td>Periodic oral exam</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Teeth cleaning (prophylaxis)</td>
<td></td>
</tr>
<tr>
<td>Bitewing X-rays (once in calendar year for all ages)</td>
<td></td>
</tr>
<tr>
<td>Intraoral X-rays</td>
<td></td>
</tr>
<tr>
<td><strong>Basic Services</strong></td>
<td></td>
</tr>
<tr>
<td>Amalgam (silver-colored) Filling</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td>Front composite (tooth-colored) Filling</td>
<td></td>
</tr>
<tr>
<td>Back Composite Filling, alternated to amalgam allowance</td>
<td></td>
</tr>
<tr>
<td>Simple Extractions</td>
<td></td>
</tr>
<tr>
<td>Crowns</td>
<td></td>
</tr>
<tr>
<td><strong>Endodontics</strong></td>
<td></td>
</tr>
<tr>
<td>Root canal</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td><strong>Periodontics</strong></td>
<td></td>
</tr>
<tr>
<td>Scaling and root planing</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong></td>
<td></td>
</tr>
<tr>
<td>Surgical Extractions</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td><strong>Major Restorative</strong></td>
<td></td>
</tr>
<tr>
<td>Onlays and Inlays</td>
<td>60% coinsurance</td>
</tr>
<tr>
<td><strong>Prosthodontics</strong></td>
<td></td>
</tr>
<tr>
<td>Dentures</td>
<td>60% coinsurance</td>
</tr>
<tr>
<td>Bridges</td>
<td></td>
</tr>
<tr>
<td>Dental Implants (covered)</td>
<td></td>
</tr>
<tr>
<td><strong>Prosthetic Repairs/Adjustments</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% coinsurance</td>
</tr>
<tr>
<td><strong>Orthodontic Services</strong></td>
<td></td>
</tr>
<tr>
<td>Adults and dependent children*</td>
<td>60% coinsurance</td>
</tr>
</tbody>
</table>

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your employee benefits booklet. In the event of a discrepancy between the information in this summary and the employee benefits booklet, the booklet will prevail.
Emergency dental treatment for the international traveler

As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program. With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

** The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Anthem. To learn more about the program, please visit the International Emergency Dental Web site at www.decaredental.com/internationalDentalProgram.do.

Finding a dentist is easy.

To select a dentist by name or location, do one of the following:

- Go to anthem.com
- Call Anthem dental customer service at the toll free number at 1-877-814-9709.

TO CONTACT US:

<table>
<thead>
<tr>
<th>Call</th>
<th>Write</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to the toll-free number at 1-877-814-9709 to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may be able to assist you with our interactive voice-response system.</td>
<td>Anthem Dental Claims  PO Box 1115  Minneapolis, MN 55440-1115</td>
</tr>
</tbody>
</table>

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross Life and Health Insurance Company.

** The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Anthem. To learn more about the program, please visit the International Emergency Dental Web site at www.decaredental.com/internationalDentalProgram.do.
Choice of dentists
While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist.

Here's why:
In-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service — called the “maximum allowed cost” — and the amount they usually charge for a service. When they bill you for this difference, it's called “balance billing.”

How Anthem dental decides on maximum allowed costs
For services from an out-of-network dentist, the maximum allowed cost is determined in one of the following ways:
- Out-of-network dental fee schedule/rate developed by Anthem, which may be updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data
- Information provided by a third-party vendor that shows comparable costs for dental services
- In-network dentist fee schedule

Here's an example of higher costs for out-of-network dental services
This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Say Ted’s dental plan allows him 50% coinsurance for either in- or out-of-network services... Ted chooses to get a crown from an out-of-network dentist who charges $1,200 for the service and bills Anthem for that amount. If Anthem's maximum allowed cost for this dental service is $800, this means there will be a $400 difference. The out-of-network dentist can “balance bill” Ted for that amount.

Ted will also need to pay $400 coinsurance. Therefore, the total he will pay the out-of-network dentist is $800. Here's the math:
- Dentist's charge: $1,200
- Anthem’s maximum allowed cost: $800
- Anthem pays 50%: $400
- Ted pays 50% (coinsurance): $400
- Balance Ted owes the provider: $1,200 - $800 = $400
- Ted's total cost: $400 coinsurance + $400 provider balance = $800

In the example, if Ted had gone to an in-network dentist, his cost would be only $400 for the coinsurance because he would not have been “balance billed” the $400 difference.
INTRODUCING BLUE VIEW VISION-Select!
Good news—Blue View Vision-Select is very flexible and easy to use. This summary outlines the basic components of your plan, including quick answers about what’s covered and much more!

STATE OF INDIANA has selected Anthem Blue View Vision Select as your vision wellness program. Blue View Vision Select offers you one of the most robust vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Anthem Blue Cross and Blue Shield members have access to one of the nation’s largest vision networks. Blue View Vision Select is the only vision plan that gives members the ability to use their in-network benefits at 1-800 CONTACTS, or choose a private practice eye doctor, or go in store to LensCrafters®, Sears OpticalSM, Target Optical®, JCPenney® Optical and most Pearle Vision® locations. Best of all – when you receive care from a Blue View Vision Select participating provider, you can maximize your benefits and money-saving discounts. Members may call Blue View Vision Select toll-free at (877) 254-9443 with questions about vision benefits or provider locations.

Out-of-Network Services
Did we mention we’re flexible? You can choose to receive care outside of the Blue View Vision Select network. You simply get an allowance toward services and you pay the rest. (In-network benefits and discounts will not apply.) Just pay in full at the time of service and then file a claim for reimbursement.

Lenses for $1,000 Lifetime Max.

<table>
<thead>
<tr>
<th>Vision Care Services</th>
<th>Member Cost</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam with Dilation as Necessary</td>
<td>$10 Copay</td>
<td>Up to $35</td>
</tr>
<tr>
<td>Contact Lens Fit and Follow-up: (A contact lens fitting and two follow-up visits are available to you once a comprehensive eye exam has been completed.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard*</td>
<td>$40 Copay</td>
<td>Up to $35</td>
</tr>
<tr>
<td></td>
<td>Paid-in-full fit and two follow up visits</td>
<td>10% off retail</td>
</tr>
<tr>
<td>Frames</td>
<td></td>
<td>Up to $35</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Up to $35</td>
</tr>
<tr>
<td>Standard Plastic Lenses:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$25 Copay</td>
<td>Up to $25</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$25 Copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$25 Copay</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Standard Polycarbonate (add-on the lens copay)</td>
<td>$20 Copay</td>
<td>N/A</td>
</tr>
<tr>
<td>Lens Option (paid by member and added to the base price of the lens):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tint</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>UV Coating</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Scratch-Resistant</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Progressive (add-on to bifocal)</td>
<td>$65</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Anti-Reflective</td>
<td>$45</td>
<td>N/A</td>
</tr>
<tr>
<td>Other Add-ons</td>
<td>20% off retail</td>
<td>N/A</td>
</tr>
<tr>
<td>Contact Lenses (allowance covers materials only):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional Elective</td>
<td>$0 Copay; $105 allowance</td>
<td>Up to $95</td>
</tr>
<tr>
<td>Disposable Elective</td>
<td>$0 Copay; $105 allowance</td>
<td>Up to $95</td>
</tr>
<tr>
<td>Non-elective</td>
<td>$0 Copay; Paid in full</td>
<td>Up to $165</td>
</tr>
<tr>
<td>Low Vision (subject to prior approval)</td>
<td>$0 Copay</td>
<td>$0 Copay</td>
</tr>
<tr>
<td></td>
<td>$1,000 Lifetime Max.</td>
<td>$1,000 Lifetime Max.</td>
</tr>
<tr>
<td>Frequency:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam</td>
<td>Once every 12 months</td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>Once every 24 months</td>
<td></td>
</tr>
<tr>
<td>Standard Plastic Lenses or Contact Lenses</td>
<td>Once every 12 months</td>
<td></td>
</tr>
</tbody>
</table>

*A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to toric and multifocal.

**A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the plan design; however, these materials and any items not covered below may be purchased at preferred pricing from a Blue View Vision Select provider. In addition, benefits are payable only for expenses incurred while the group and insured person’s coverage is in force. Combined Offers. Not combined with any offer, coupon, or in-store advertisement; Experimental or Investigative. Any experimental or investigative services or materials; Crime or Nuclear Energy. Conditions that result from: (1) insured person’s commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available; Uninsured. Services received before insured person’s effective date or after coverage ends; Excess Amounts. Any amounts in excess of covered vision expense; Experimental or Investigative. Provided that the plan does not cover services for which no charge is made in the absence of insurance coverage; Not Specifically Listed. Services not specifically listed in this plan as covered services; Private Contracts. Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act; Eye Surgery. Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery; Sunglasses. Sunglasses and accompanying frames; Safety Glasses. Safety glasses and accompanying frames; Hospital Care. Inpatient or outpatient hospital vision care; Orthoptics. Orthoptics or vision training and any associated supplemental testing; Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power; Lost or Broken Lenses or Frames. Any lost or broken lenses or frames, unless insured person has reached a new benefit period; Frames: Discount is not available on certain frame brands in which the manufacturer imposes a no discount policy.

Contact Lens Fit and Follow-up:  
Exam with Dilation as Necessary   $10 Copay    Up to $35
Contact Lens Fit and Follow-up: (A contact lens fitting and two follow-up visits are available to you once a comprehensive eye exam has been completed.)
Standard*            $40 Copay           Up to $35
Premium**           10% off retail       Up to $35
Frames               Up to $110 allowance   Up to $35
Standard Plastic Lenses:
Single Vision         $25 Copay           Up to $25
Bifocal               $25 Copay           Up to $40
Trifocal              $25 Copay           Up to $55
Standard Polycarbonate (add-on the lens copay) $20 Copay N/A
Lens Option (paid by member and added to the base price of the lens):
Tint                   $15           N/A
UV Coating             $15           N/A
Standard Scratch-Resistant $15 N/A
Standard Progressive (add-on to bifocal) $65 N/A
Standard Anti-Reflective $45 N/A
Other Add-ons          20% off retail       N/A
Contact Lenses (allowance covers materials only):
Conventional Elective $0 Copay; $105 allowance Up to $95
Disposable Elective  $0 Copay; $105 allowance Up to $95
Non-elective         $0 Copay; Paid in full Up to $165
Low Vision (subject to prior approval) $0 Copay $0 Copay $1,000 Lifetime Max. $1,000 Lifetime Max.
Frequency: Exam Once every 12 months
Frames               Once every 24 months
Standard Plastic Lenses or Contact Lenses Once every 12 months

* A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to toric and multifocal.

** A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the plan design; however, these materials and any items not covered below may be purchased at preferred pricing from a Blue View Vision Select provider. In addition, benefits are payable only for expenses incurred while the group and insured person’s coverage is in force. Combined Offers. Not combined with any offer, coupon, or in-store advertisement; Experimental or Investigative. Any experimental or investigative services or materials; Crime or Nuclear Energy. Conditions that result from: (1) insured person’s commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available; Uninsured. Services received before insured person’s effective date or after coverage ends; Excess Amounts. Any amounts in excess of covered vision expense; Experimental or Investigative. Provided that the plan does not cover services for which no charge is made in the absence of insurance coverage; Not Specifically Listed. Services not specifically listed in this plan as covered services; Private Contracts. Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act; Eye Surgery. Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery; Sunglasses. Sunglasses and accompanying frames; Safety Glasses. Safety glasses and accompanying frames; Hospital Care. Inpatient or outpatient hospital vision care; Orthoptics. Orthoptics or vision training and any associated supplemental testing; Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power; Lost or Broken Lenses or Frames. Any lost or broken lenses or frames, unless insured person has reached a new benefit period; Frames: Discount is not available on certain frame brands in which the manufacturer imposes a no discount policy.
# Blue View Vision Select Additional Savings

**Members Savings**

<table>
<thead>
<tr>
<th>Discount</th>
<th>Off Retail Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>40% discount</td>
<td>40%</td>
</tr>
<tr>
<td>15% off retail price</td>
<td>15%</td>
</tr>
<tr>
<td>20% off retail price</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Additional Pair of Complete Eyeglasses

Contact Lenses - Conventional

(Discount applied to materials only)

Visit [www.eyemedcontacts.com](http://www.eyemedcontacts.com) to order replacement contact lenses for shipment to your home at less than retail price.

### Eyewear Accessories

Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases, etc.

*Items purchased separately are discounted 20% off the retail price. Blue View Vision Select’s Additional Savings Program is subject to change without notice.

### Laser Vision Correction Surgery

Glasses or contacts may not be the answer for everyone. That’s why we offer further savings with discounts on refractive surgery. Pay a discounted amount per eye for LASIK Vision correction. For more information, go to SpecialOffers at [www.anthem.com/specialoffers](http://www.anthem.com/specialoffers) and select vision care.

### Using Your Blue View Vision Select Plan

The Blue View Vision Select network is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

### Out-of-Network

If you choose an out-of-network provider, please complete the out-of-network claim form and submit it along with your itemized receipt to the below fax number, email address, or mailing address. When visiting an out-of-network provider, you are responsible for payment of services and/or eyewear materials at the time of service.

- **To Fax:** 866-293-7373
- **To Email:** oonclaims@eyewearspecialoffers.com
- **To Mail:** Blue View Vision Select
  
  Attn: OON Claims
  
  P.O. Box 8504
  
  Mason, OH 45040-7111

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In Indiana: Anthem Blue Cross and Blue Shield is a trade name of Anthem Insurance Companies, Inc. In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc. In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWi collectively underwrite or administer the POS policies. In Missouri: Anthem Blue Cross and Blue Shield is the trade name RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC) and HMO Missouri, Inc. use to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensee of the Blue Cross and Blue Shield Association. © Blue Cross and Blue Shield are registered marks of the Blue Cross and Blue Shield Association.
Life Insurance Coverage

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 three types of coverage; basic, supplemental and dependent life insurance. During this Open Enrollment, take the time to review your finances and consider which option and coverage amount would be best for you and your family.

Some life insurance changes that can be completed within your Open Enrollment event. These changes include decreasing your coverage level or dropping any of your life insurance plans. You may also elect child dependent life insurance in increments of $5,000 up to and including $20,000 for your children as long as you are currently enrolled in basic life insurance. Additionally you may update your beneficiary information and/or allocation amounts. All changes will be effective in January.

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 increasing your coverage level and/or adding an eligible spouse to your dependent life insurance plan. This process applies to all three life insurance plans sponsored by the State of Indiana (basic, supplemental and dependent life).

The EOI application can be completed online at any time at www.LifeBenefits.com/SubmitEOI. On average the application takes 10 to 30 minutes to complete. Instructions on how to submit EOI through Securian can be found at www.in.gov/spd/2868.htm. Once submitted, Securian will review your application and inform both you and SPD Benefits of its decision. If approved, SPD Benefits will make the appropriate changes to your life insurance plans and start 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. Instruction on how to change your life insurance beneficiaries can be found at www.in.gov/spd/2868.htm. Please remember, 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 Dec. 31, 2016, will be limited to $200,000 of supplemental life insurance coverage. Employees attaining age 65 during the plan year will automatically be reduced to $200,000 of supplemental life insurance coverage and their payroll deductions adjusted accordingly.
Why do I need this insurance?

Group Term Life insurance, underwritten by Minnesota Life Insurance Company, can protect your family’s financial future from the unexpected loss of your life and income during your working years.

Life insurance proceeds can be an important tool in helping your family afford final expenses, such as funeral and medical bills, as well as day-to-day financial obligations.
ENROLL IN YOUR GROUP LIFE INSURANCE PROGRAM

Additional features

Beyond paying a benefit in the event of your death, your group life insurance has other important features:

• Accidental Death and Dismemberment (AD&D) – Provides beneficiaries with additional financial protection if an insured’s death or dismemberment is due to a covered accident, whether it occurs at work or elsewhere.

• Take your coverage with you – If you are no longer eligible for coverage as an active employee, you may port your Basic and Supplemental Life coverage (portable coverage ends at age 70) or you may convert your life coverage to an individual life insurance policy. Premiums may be higher than those paid by active employees.

• Early benefit payments if diagnosed as terminally ill – If an insured person becomes terminally ill with a life expectancy of 12 months or less, he/she may request early payment of up to 100 percent of the life insurance amount, up to a maximum of $1,000,000 (Basic and Supplemental combined).

Basic coverage

Basic Term Life and Accidental Death & Dismemberment (AD&D)

1.5x annual salary
- Includes matching AD&D benefit
- All coverage is guaranteed if elected within initial eligibility period
- A portion of this coverage paid for by State of Indiana

Bi-weekly cost of coverage

Basic Term Life and AD&D:
$0.113 per $1,000 of salary

Supplemental Term Life

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 39</td>
<td>$0.048</td>
</tr>
<tr>
<td>40-44</td>
<td>0.078</td>
</tr>
<tr>
<td>45-49</td>
<td>0.126</td>
</tr>
<tr>
<td>50-54</td>
<td>0.194</td>
</tr>
<tr>
<td>55-59</td>
<td>0.311</td>
</tr>
<tr>
<td>60-64</td>
<td>0.446</td>
</tr>
<tr>
<td>65 and older</td>
<td>0.718</td>
</tr>
</tbody>
</table>

Rates increase with age.

Spouse Term Life

<table>
<thead>
<tr>
<th>Coverage amount</th>
<th>Bi-weekly rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse only - $5,000</td>
<td>$0.720</td>
</tr>
<tr>
<td>Spouse only - $10,000</td>
<td>1.440</td>
</tr>
<tr>
<td>Spouse only - $15,000</td>
<td>2.160</td>
</tr>
<tr>
<td>Spouse only - $20,000</td>
<td>2.880</td>
</tr>
</tbody>
</table>

Child Term Life

<table>
<thead>
<tr>
<th>Coverage amount</th>
<th>Bi-weekly rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child only - $5,000</td>
<td>$0.450</td>
</tr>
<tr>
<td>Child only - $10,000</td>
<td>0.900</td>
</tr>
<tr>
<td>Child only - $15,000</td>
<td>1.350</td>
</tr>
<tr>
<td>Child only - $20,000</td>
<td>1.800</td>
</tr>
</tbody>
</table>

Spouse and Child Term Life Packages

<table>
<thead>
<tr>
<th>Coverage amount</th>
<th>Bi-weekly rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse $5,000/Child $5,000</td>
<td>$1.00</td>
</tr>
<tr>
<td>Spouse $10,000/Child $10,000</td>
<td>2.00</td>
</tr>
<tr>
<td>Spouse $15,000/Child $15,000</td>
<td>3.00</td>
</tr>
<tr>
<td>Spouse $20,000/Child $20,000</td>
<td>4.00</td>
</tr>
</tbody>
</table>

All rates are subject to change.

Here’s the easy math to your bi-weekly premium:

Total coverage you need    $___________
÷ 1,000                      ______________
× your rate                  $___________
= Bi-weekly premium          $___________
Protect your family from the unexpected loss of your life and income during your working years.

### Coverage options
You must be enrolled in Basic Term Life and Accidental Death & Dismemberment (AD&D) to elect any of the coverages shown below.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Spouse Term Life</th>
<th>Child Term Life</th>
<th>Spouse and Child Term Life Packages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental Term Life</td>
<td>$5,000, $10,000, $15,000 or $20,000</td>
<td>$5,000, $10,000, $15,000 or $20,000</td>
<td></td>
</tr>
<tr>
<td>Spouse Term Life</td>
<td>$5,000, $10,000, $15,000 or $20,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Term Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10,000 increments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum coverage: $500,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any elections or increases require Evidence of Insurability (EOI)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse $5,000/Child $5,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse $10,000/Child $10,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse $15,000/Child $15,000</td>
<td>Package elections require the spouse and child to have the same coverage amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse $20,000/Child $20,000</td>
<td>If you elect a package, you cannot elect separate Spouse Term Life or Child Term Life coverage amounts</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Children are eligible from live birth to the end of the month in which they turn 26 years old.

### QUESTIONS?
Visit [http://www.in.gov/spd/2868.htm](http://www.in.gov/spd/2868.htm) or call 317-232-1167 (Indianapolis) or 1-877-248-0007 (outside Indianapolis).

### Why Life Insurance?
Learn how life insurance can protect your financial future.

Scan here with your smart phone or tablet, or visit LifeBenefits.com/videos/Term, to view a short video about your life insurance program.
Are you a new employee to the State of Indiana?

As a newly eligible employee, you have a one-time opportunity to elect guaranteed coverage – no health questions asked – for you and your family during your initial eligibility period.

The following guaranteed coverage amounts are available:

- Basic Term Life and Accidental Death & Dismemberment (AD&D) – 1.5x annual salary
- Supplemental Term Life – Up to $200,000
- Spouse Term Life – Up to $20,000
- Child Term Life – All coverage is guaranteed

Elections after your initial eligibility period and amounts exceeding the guaranteed issue limit require Evidence of Insurability (EOI).
Carrier Contact Information

Addresses, phone numbers and websites

Medical
Anthem Insurance Companies, Inc.
P. O. Box 390
Indianapolis, IN 46206
Customer Service: 1-877-814-9709
TDD: 1-800-475-5462
www.anthem.com

Dental
Anthem Dental Complete
Anthem Insurance Companies, Inc.
P.O. Box 390
Indianapolis, IN 46206
TDD: 1-800-475-5462
www.anthem.com

Vision
Anthem Blue View Vision Select
Anthem Insurance Companies, Inc.
P. O. Box 390
Indianapolis, IN 46206
Customer Service: 1-877-254-9443
www.anthem.com

Health Savings Accounts
The HSA Authority
P.O. Box 1454
Fort Wayne, IN 46858
Customer Service: 1-888-472-8697
www.theHSAauthority.com
Employer Code # 100366

Prescriptions Program
Express Scripts
Customer Service: 1-877-841-5241
www.express-scripts.com

Flexible Spending Accounts
Key Benefit Administrators, Inc.
P. O. Box 55210
Indianapolis, IN 46205-0210
Customer Service: 1-800-558-5553
www.keyqualifiedplans.com

Life Insurance
Securian Life Insurance Company
400 Robert Street North
St. Paul, MN 55101-2098
Customer Service: 1-866-293-6047
www.LifeBenefits.com

Employee Assistance Program
Anthem EAP
Customer Service: 1-800-223-7723
www.anthemeap.com

Anthem 24/7 NurseLine
1-888-279-5449

Castlight
Web: https://mycastlight.com/stateofindiana/
Phone: 888-920-1264
Email: support@castlighthealth.com

HumanaVitality/Go365 (2017)
Web: www.humana.com/vitality/
Customer Service: 1-800-708-1105

Health and Wellness Center
Indiana Government Center - South
402 W. Washington St., Room W041
Indianapolis, IN 46204
317.963.2035
www.investinyourhealthindiana.com/hawc/

Contact the Benefits Hotline toll-free at 1-877-248-0007 outside of Indianapolis or 317-232-1167 within the Indianapolis area. Benefit specialists are available from 7:30 a.m. to 5 p.m. Monday through Friday, Eastern Standard Time.

You may also email your questions to SPDBenefits@spd.in.gov.
Eligibility Requirements to Enroll

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 37½ hours per week. Part-time, intermittent and hourly (temporary) employees working an average of thirty (30) or more hours per week over a 12-month review period would also be eligible for benefits. Part-time, intermittent and hourly (temporary) employees working less than thirty (30) or more hours per week over a 12-month review period are not eligible for insurance or related benefits.

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 19, and
   ii.) meets the following disability criteria, prior to age 19:
      • (I) is incapable of self-sustaining employment by reason of mental or physical disability,
      • (II) resides with the employee at least six (6) months of the year, and
      • (III) receives 50% of his or her financial support from the parent
   such child’s eligibility for coverage shall continue, if satisfactory evidence of such disability and dependency is received by the State or its third party administrator in accordance with disabled dependent certification and recertification procedures. Eligibility for coverage of the “Dependent” will continue until the employee discontinues his coverage or the disability criteria is no longer met. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible Dependent for enrollment so long as no break in Coverage longer than 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.

Please Note: If you wish to enroll a dependent onto your plans during Open Enrollment who is over the age of 26 and meets the definition of a disabled dependent but was not certified last year, please call the Benefits Hotline at 317-232-1167 or toll free at 877-248-0007, if outside the 317 area code, to initiate the disabled dependent certification process with Anthem. To be eligible to enroll your dependent(s) as part of your Open Enrollment event for an effective date of January 1, 2017, you must contact the Benefits Hotline during Open Enrollment and Anthem must certify that your dependent(s) meets the definition of a disabled dependent.

If you have questions or concerns about dependent coverage, please feel free to contact State Personnel at 1-877-248-0007 outside the 317 area code or 317-232-1167 locally.

Qualifying Events

Qualifying events allow for changes

After 4:00 p.m. (EST) on Wednesday, Nov. 9, you will not be able to make changes to your benefits. This means you must be certain you have elected the coverage that is right for you and added all eligible dependents who 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. Examples of qualifying events include:

• 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 will not be 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.

Dual Coverage

Dual coverage is not allowed under any 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 coverage,
and the other may waive coverage, or one may carry family coverage 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 will have the choice to continue your retiree coverage and waive your active employee coverage, or vice versa. However, you will not be permitted to carry state retiree insurance and active state employee coverage simultaneously. Dual coverage is only permitted for dependent life.

**Women’s Health and Cancer Rights Act (WHCRA) 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.

**HIPAA Notice of Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your, 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.

To request special enrollment or obtain more information, contact Anthem toll free at 1-877-814-9709.

**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).

**View the following notices on the Open Enrollment website**

**Notice of Privacy Practices**

**Uniformed Services Employment and Reemployment Rights Act (USERRA) document**
NOTICE REGARDING WELLNESS PROGRAM

Indiana’s Humana Go365 wellness program & non-tobacco use incentives are voluntary and available to all individuals enrolled in the State employee health insurance plans. The programs are administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in Humana Go365 you will be encouraged to complete:

- a voluntary health risk assessment or “HRA” that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease); and
- a biometric screening, which will include a blood test for total cholesterol, HDL, LDL, triglycerides and fasting blood glucose.

You are not required to complete the HRA or to participate in the blood test or other medical examinations. However, employees who choose to participate in Humana Go365 may receive incentives of:

- Wellness “Bucks” (up to an approximate cash value of $300 for participation in certain health-related activities such as: tracking workouts, health education courses, goal setting and health coaching).
- Eligibility for the Wellness CDHP financial incentives (i.e., lower premiums and higher Health Savings Account contributions, for reaching an Earned Status of Silver or higher by the annual deadline).

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you Humana Go365 services, such as goal setting, educational activities, fitness recommendations, or health coaching. You also are encouraged to share your results or concerns with your own doctor.

Additional incentives (such as a $35 bi-weekly premium discount) may be available for plan participants who participate in certain health-related activities (e.g., enter into the Non-Tobacco Use Agreement).

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Benefits Hotline: SPDBenefits@spd.in.gov or 877-248-0007.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the State of Indiana may use aggregate information it collects to design a program based on identified health risks in the workplace, Humana Go365 will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with Humana Go365 will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in Humana Go365. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are registered/licensed health care providers (in order to provide you with services), or as necessary for plan administration.

(continued on page 44)
Legal Notices

(continued from page 43)

In addition, all medical information obtained through Humana Go365 will be maintained separate from your personnel records, information stored electronically will be protected, and no information you provide as part of Humana Go365 will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, or complaints about the wellness program, please contact the Benefits Hotline:

Wellness Program

(continued from page 10)

LiveHealth Online

**Service Key** and **Coupon Code** to be used in LiveHealth.

- Go to [livehealthonline.com](http://livehealthonline.com).
- Sign up or log in to LiveHealth Online.
  - 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](http://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**, and choose the appointment tab. You can schedule an appointment by date or therapist. After scheduling the appointment, you receive a confirmation email.
- Fifteen minutes before your appointment you 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 three free visits. This reduces the member cost share to $0.
- You are then connected to the therapist.

Sign up for LiveHealth today by visiting [InvestInYourHealthIndiana.com](http://InvestInYourHealthIndiana.com) or downloading the mobile app from your app store.
Carrier/vendor fair
An event where representatives from plan providers are available to answer questions about coverages provided by their plans.

Claim
Request for payment that the member or their health care provider submits to the health insurer, when services or supplies believed to be covered are provided.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
Federal law that allows you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee or another qualifying event.

Co-insurance
Percentage of allowed charges for covered services a member is required to pay after the deductible has been met and up to the out-of-pocket maximum. For example, health insurance may cover 70% of charges for particular service; the member is responsible for the remaining 30%. In this example the 30% is the co-insurance.

Consumer-Driven Health Plan (CDHP)
Health insurance plan which encourages members to become actively involved in making their own healthcare decisions (i.e., selecting healthcare providers with the lowest cost and highest quality, when receiving services and managing their own fitness and wellness). This type of plan features higher deductibles compared to that of what is known as traditional insurance plans. CDHPs can be paired with a health savings account (HSA) to allow a member to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

Deductible
Dollar amount an employee must pay for medical and prescription services before their health insurance plan begins to pay. This amount varies based upon the plan and coverage level chosen by the employee. These costs can be covered pre-tax by the funds in a HSA if the health plan is a CDHP. Otherwise, they are paid by the employee's personal financial means.

Dependent(s)
(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 19, and
   ii.) meets the following disability criteria, prior to age 19:
       • (I) is incapable of self-sustaining employment by reason of mental or physical disability,
       • (II) resides with the employee at least six (6) months of the year, and
   • (III) receives 50% of his or her financial support from the parent
such child’s eligibility for coverage shall continue, if satisfactory evidence of such disability and dependency is received by the State or its third party administrator in accordance with disabled dependent certification and recertification procedures. Eligibility for coverage of the “Dependent” will continue until the employee discontinues his coverage or the disability criteria is no longer met. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible Dependent for enrollment so long as no break in Coverage longer than 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.

Please Note: If you wish to enroll a dependent onto your plans during Open Enrollment who is over the age of 26 and meets the definition of a disabled dependent but was not certified last year, please call the Benefits Hotline at 317-232-1167 or toll free at 877-248-0007, if outside the 317 area code, to initiate the disabled dependent certification process with Anthem. To be eligible to enroll your dependent(s) as part of your Open Enrollment event for an effective date of January 1, 2017, you must contact the Benefits Hotline during Open Enrollment and Anthem must certify that your dependent(s) meets the definition of a disabled dependent.

Dependent Care (Flexible Spending Account)
FSA established to pay for certain expenses to care for the dependents of an employee while working (married spouse must be employed as well). While this most commonly means child care, for children under the age of 13, it can also be used for children of any age who are physically or mentally incapable of self-care. It can additionally be used for adult day care for senior citizen tax dependents who reside with the employee, such as parents or grandparents. The maximum annual contribution limit is $5,000.

Dual coverage
Enrollment of a member in more than one state-sponsored insurance plan with the same type of benefits. The state does not allow its employees to have dual coverage.

Employer contribution
Fees paid by an employer toward the cost of its employees’ coverage.

Enrollee/subscriber/member
With the State of Indiana, the employee is the enrollee.

Enrollment
Process by which an employee chooses the insurance plans/coverage that best meets their needs. State employees do this online through the PeopleSoft system.
Glossary

Exclusion
Specific listed services or circumstances that are defined in the insurance contract for which benefits will not be provided.

Explanation of Benefits (EOB)
Statement provided to the member by the health insurance plan explaining the benefit calculations and payment of medical services. It details services rendered and benefits paid or denied for each claim submitted. An EOB lists the charges submitted, amount allowed, amount paid and any balance possibly owed as the patient’s responsibility.

Family coverage
An employee and at least one eligible dependent enrolled in an insurance plan.

Family and Medical Leave Act (FMLA)
Federal law that guarantees up to 12 weeks of job-protected leave for employees if they need to take time off due to serious illness or disability, have/adopt a child or to care for another family member.

Family status change/qualifying event
Personal change in status which may allow an employee to modify their benefit elections.

Examples are, but not limited to, the following:
1. Change in legal marital status – marriage, divorce, legal separation, annulment or death of a spouse
2. Change in number of dependents – birth, death, adoption, placement for adoption, award of legal guardianship
3. Change in employment status of the employee’s spouse or employee’s dependent – switching from part-time to full-time employment status or from full-time to part-time, termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence which results in employee/dependent becoming ineligible for coverage
4. Dependent satisfies or ceases to satisfy eligibility requirement – such as attainment of the limiting age. See DEPENDENT.

Qualifying events are defined by the IRS and must be reported to the Benefits Hotline within 30 calendar days of the event occurring.

Flexible Spending Account (FSA)
Account offered to employees which allow a fixed amount of pre-tax money to be set aside for qualified medical expenses. That amount must be determined in advance and employees pay it back over the course of the 26 pay periods of the calendar year. Any money not spent out of the account by the end of the calendar year is lost to the employee. The maximum annual contribution limit is $2,500.

Formulary
A list of medications that are approved to be prescribed under a prescription drug plan. The development of formularies is based on evaluations of efficacy, safety and cost-effectiveness.

Front-load (HSA)
Initial contribution the state makes into an employee’s HSA. The state front loads approximately 50% of its annual contribution commitment into the employee’s HSA at the beginning of each calendar year. The remainder of the contribution is divided among the remaining 26 pay periods. See HEALTH SAVINGS ACCOUNT or further information.

Health Insurance Portability and Accountability Act (HIPAA) of 1996
Designed to streamline all areas of the health care industry and to provide additional rights and protections to participants in health plans.

Health Savings Account (HSA)
Account created for employees covered under a CDHP to save for medical expenses with pre-tax contributions, made by the state and can be made by the employee. Contributions can also be made by third parties. If an employee chooses to contribute to the HSA, that money is deducted from their pay check on a pre-tax basis. The amount that the employee contributes can be changed at any time throughout the year by contacting the Benefits Hotline. The maximum contribution limit for a HSA paired with a single coverage CDHP is $3,400; for family coverage, the limit is $6,650. This includes contributions from the state, the employee and any third-part contributions.

Employees 55 and older may make an additional $1,000 catch-up contribution until they enroll in Medicare. The money in the HSA can be used to pay for qualified medical expenses, which include most medical care such as dental, vision and prescription drugs. Any money not spent out of the account by the end of the calendar year rolls over and remains in the account until it is spent. If the money in an HSA is used for anything other than qualified medical expenses, it can become a taxable event. Eligible medical expenses are defined by the IRS and can be found in Publication 929.

Immunizations
Vaccines against certain diseases, which can be administered either orally or by injection (i.e., flu shots).

In-network
Healthcare providers who contract with the insurance plan to provide services at a discounted rate.

Limited Purpose Medical Spending Account (Flexible Spending Account)
If someone has an HSA and elects to have a Flexible Spending Account (FSA), the FSA becomes a Limited Purpose Medical Spending Account. Expenses under the Limited Purpose Medical Spending Account are limited to:
• Dental care services/treatments,
• Vision care services/treatments,
• Preventive care services - limited to diagnostic procedures and services or treatment taken to prevent the onset of a disease or condition that is immediately possible. This
Glossary

...does not include services/treatments to treat an existing condition. A diagnosis or letter of medical necessity may be required to consider claim reimbursement. See also Flexible Spending Account

Mail order pharmacy
Alternate to retail pharmacies, members can order and refill prescriptions via mail, Internet, fax or telephone in 90-day quantities. Prescriptions are mailed directly to the member’s home. All state health insurance plans cover mail order pharmacy through Express Scripts or the pharmacy benefit provider.

Maintenance drug
Medication anticipated to be taken on an ongoing basis for at least several months to treat a chronic condition such as diabetes, high blood pressure, asthma, etc.

Medical Flexible Spending Account
See Flexible Spending Account

Member
Eligible individual enrolled in an insurance plan; member may be the employee or any dependent.

Network
Group of medical professionals contracted to provide services to members of a health insurance plan.

Non-Tobacco Use Incentive
Agreement to which an employee commits and signs (electronically) to not use tobacco for the benefit year and agrees to random tobacco testing. The incentive is only available to employees enrolled in medical coverage.

If an employee accepts the Non-Tobacco Use Incentive and later uses tobacco, that employee will be terminated. The only exception to the job loss penalty is if the employee revokes the agreement by logging in to PeopleSoft and completing the self-service process to revoke their agreement prior to the use of any tobacco product.

Open Enrollment
Specific time of year when employees can enroll in state-offered benefits.

For benefit year 2017, Open Enrollment is Oct. 19 through 4 p.m., Nov. 9 (EST). Changes you make during Open Enrollment take effect Jan. 1, 2017.

Out-of-pocket costs
Expenses for medical care that are not reimbursed by insurance. This includes all deductibles and co-insurance paid under the insurance plan. Costs can be covered pre-tax by the funds in a HSA if the health plan is a CDHP or FSA. Otherwise they are paid by the member’s personal financial means.

Out-of-pocket maximum
Limit set on each insurance plan that caps the maximum a member has to pay for medical services during a calendar year.

This includes all deductibles and co-insurance paid under the insurance plan. These costs can be covered pre-tax by the funds in a HSA if the health plan is a CDHP or FSA. Otherwise they are paid by the member’s personal financial means. Premiums do not count toward out-of-pocket maximums. Employees must still pay premiums, even if they meet their out-of-pocket maximum.

Participating provider
Individual physicians, hospitals and professional health care providers who have a contract to provide services to a network’s members at a discounted rate and to be paid directly for covered services. See Network.

Prior-authorization
Approval required for specifically designated procedures or hospital admissions. When care is received in-network, the primary care physician or specialist is usually responsible for obtaining pre-authorization. For out-of-network services, the member is responsible for obtaining pre-authorization.

Premium
Amount each employee pays for an elected health plan.

Prescription medication
FDA-approved medicine regulated by legislation to require a medical prescription before it can be obtained.

Preventive care/services
Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Services are covered 100% by all insurance plans by law (i.e. annual physicals, well baby visits, flu shots, etc.).

Provider
Person, organization or institution licensed to provide health care services.

Self-insurance
Practice of an employer that assumes complete responsibility for losses, which might be insured against, such as health care expenses. In effect, self-insured groups have no real insurance against potential losses and instead maintain a fund out of which is paid the contingent liability subject to self-insurance. The state is self-insured.

Termination of Coverage Date
The actual date the coverage ceased.

Webinar
Short for web-based seminar; a presentation, lecture, workshop or seminar that is transmitted over the Internet.

Wellness program
Health management program which incorporates the components of disease prevention, medical self-care and health promotion.
Creditable Coverage Disclosure Notice
For Plan Year 2017
Important Notice from Indiana State Personnel Department
About Your Prescription Drug Coverage and Medicare

You are receiving this notice because you or a family member may be eligible for or currently enrolled in Medicare. However, if you are not enrolled in Medicare, you may disregard this notice. If you enroll in Medicare at a later date, please be sure to review this document. You can also find this document on the Indiana State Personnel Department’s Benefits website at http://www.in.gov/spd/2337.htm.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with a State of Indiana employee group pharmacy benefit plan and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The State of Indiana’s Third Party Administrators determined that the prescription drug coverage offered by Express Scripts is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan and still meet the eligibility for the State of Indiana health plan, your current employee coverage will not be affected. You may continue your State of Indiana employee coverage and elect part D and this plan will coordinate with Part D coverage.
If you do decide to join a Medicare drug plan and drop your current State of Indiana employee health plan that includes prescription drug coverage, be aware that you and your dependents may not be able to enroll in the State’s plan except during an open enrollment period.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with the State of Indiana health plan that includes prescription drug coverage and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**For More Information About This Notice Or Your Current Prescription Drug Coverage:**

Contact the Benefits Division for further information at 317-232-1167 or outside the 317 area code, 877-248-0007. **NOTE:** You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the State of Indiana changes. You also may request a copy of this notice at any time.

**For More Information About Your Options Under Medicare Prescription Drug Coverage:**

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

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<table>
<thead>
<tr>
<th>Date:</th>
<th>October 4, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sender:</td>
<td>Indiana State Personnel Department</td>
</tr>
<tr>
<td>Office:</td>
<td>Benefits Division</td>
</tr>
<tr>
<td>Address:</td>
<td>402 W. Washington Street, W161</td>
</tr>
<tr>
<td></td>
<td>Indianapolis, IN 46204</td>
</tr>
<tr>
<td>Phone Number:</td>
<td>317-232-1167 local, or 877-248-0007 outside the 317 area code</td>
</tr>
</tbody>
</table>

Equal Opportunity Employer State of Indiana www.IN.gov/spd
Discrimination is Against the Law

State of Indiana Employee Health Plans comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. State of Indiana Employee Health Plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

State of Indiana Employee Health Plans:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact State Personnel, Employee Relations Division.

If you believe that the State of Indiana Employee Health Plans have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: State Personnel Department, Employee Relations Division, 402 W. Washington St, Room W161, Indianapolis, IN 46204, 1-855-773-4647, V/TTY 1-317-232-4555, Fax 317-232-3089, Email EmployeeRelations@spd.in.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the State Personnel Employee Relations Division is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:


ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-248-0007 (TTY: 1-317-232-4555) पर कॉल करें।
Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
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<tbody>
<tr>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a></td>
<td>Website: <a href="http://flmedicaidplrecovery.com/hipp">http://flmedicaidplrecovery.com/hipp</a></td>
</tr>
<tr>
<td>Phone: 1-855-692-5447</td>
<td>Phone: 1-877-357-3268</td>
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<tr>
<th>ALASKA – Medicaid</th>
<th>GEORGIA – Medicaid</th>
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<tr>
<td>The AK Health Insurance Premium Payment Program</td>
<td>Website: <a href="http://dhc.georgia.gov/medicaid">http://dhc.georgia.gov/medicaid</a></td>
</tr>
<tr>
<td>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
<td>- Click on Health Insurance Premium Payment (HIPP)</td>
</tr>
<tr>
<td>Phone: 1-866-251-4861</td>
<td>Phone: 404-656-4507</td>
</tr>
<tr>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
<td>Medicaid Eligibility:</td>
</tr>
<tr>
<td>Medicaid Eligibility:</td>
<td><a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
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<tr>
<th>ARKANSAS – Medicaid</th>
<th>INDIANA – Medicaid</th>
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<tbody>
<tr>
<td>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a></td>
<td>Healthy Indiana Plan for low-income adults 19-64</td>
</tr>
<tr>
<td>Phone: 1-855-MyARHIPP (855-692-7447)</td>
<td>Website: <a href="http://www.hip.in.gov">http://www.hip.in.gov</a></td>
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<tr>
<td></td>
<td>Phone: 1-877-438-4479</td>
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<tr>
<td></td>
<td>All other Medicaid</td>
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<tr>
<td></td>
<td>Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a></td>
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<td></td>
<td>Phone 1-800-403-0864</td>
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<tr>
<th>COLORADO – Medicaid</th>
<th>IOWA – Medicaid</th>
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<tbody>
<tr>
<td>Medicaid Website: <a href="http://www.colorado.gov/hcpf">http://www.colorado.gov/hcpf</a></td>
<td>Website: <a href="http://www.dhs.state.ia.us/hipp">http://www.dhs.state.ia.us/hipp</a></td>
</tr>
<tr>
<td>Medicaid Customer Contact Center: 1-800-221-3943</td>
<td>Phone: 1-888-346-9562</td>
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<tr>
<td>State</td>
<td>Medicaid Website</td>
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<tr>
<td>KENTUCKY – Medicaid</td>
<td><a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
</tr>
<tr>
<td>LOUISIANA – Medicaid</td>
<td><a href="http://dhhs.louisiana.gov/index.cfm/subhome/1/n/331">http://dhhs.louisiana.gov/index.cfm/subhome/1/n/331</a></td>
</tr>
<tr>
<td>MASSACHUSETTS – Medicaid and CHIP</td>
<td><a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a></td>
</tr>
<tr>
<td>OKLAHOMA – Medicaid and CHIP</td>
<td><a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
</tr>
<tr>
<td>MISSOURI – Medicaid</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
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<tr>
<td>MONTANA – Medicaid</td>
<td><a href="http://dhphs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dhphs.mt.gov/MontanaHealthcarePrograms/HIPP</a></td>
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<tr>
<td>PENNSYLVANIA – Medicaid</td>
<td><a href="http://www.dhs.pa.gov/hip">http://www.dhs.pa.gov/hip</a></td>
</tr>
<tr>
<td>NEBRASKA – Medicaid</td>
<td><a href="http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx">http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx</a></td>
</tr>
<tr>
<td>RHODE ISLAND – Medicaid</td>
<td><a href="http://www.eohris.ri.gov/">http://www.eohris.ri.gov/</a></td>
</tr>
<tr>
<td>NEVADA – Medicaid</td>
<td><a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a></td>
</tr>
<tr>
<td>SOUTH CAROLINA – Medicaid</td>
<td><a href="http://www.sdhhss.gov">http://www.sdhhss.gov</a></td>
</tr>
<tr>
<td>SOUTH DAKOTA - Medicaid</td>
<td>WASHINGTON – Medicaid</td>
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<tr>
<td>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
<td>Website: <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a></td>
</tr>
<tr>
<td>Phone: 1-888-828-0059</td>
<td>Phone: 1-800-562-3022 ext. 15473</td>
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<tr>
<th>TEXAS – Medicaid</th>
<th>WEST VIRGINIA – Medicaid</th>
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<tbody>
<tr>
<td>Phone: 1-800-440-0493</td>
<td>Phone: 1-877-598-5820, HMS Third Party Liability</td>
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<tr>
<th>UTAH – Medicaid and CHIP</th>
<th>WISCONSIN – Medicaid and CHIP</th>
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<tr>
<td>Phone: 1-877-543-7669</td>
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<tr>
<th>VERMONT– Medicaid</th>
<th>WYOMING – Medicaid</th>
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<tr>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
<td>Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a></td>
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<tr>
<td>Phone: 1-800-250-8427</td>
<td>Phone: 307-777-7531</td>
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<th>VIRGINIA – Medicaid and CHIP</th>
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<tr>
<td>Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
<td></td>
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<tr>
<td>Medicaid Phone: 1-800-432-5924</td>
<td></td>
</tr>
<tr>
<td>CHIP Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
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</tr>
<tr>
<td>CHIP Phone: 1-855-242-8282</td>
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To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

- **U.S. Department of Labor**
  - Employee Benefits Security Administration
  - [www.dol.gov/ebsa](http://www.dol.gov/ebsa)
  - 1-866-444-EBSA (3272)

- **U.S. Department of Health and Human Services**
  - Centers for Medicare & Medicaid Services
  - [www.cms.hhs.gov](http://www.cms.hhs.gov)
  - 1-877-267-2323, Menu Option 4, Ext. 61565

**Paperwork Reduction Act Statement**

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

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

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans offer the services listed in this preventive care flier at no cost to you.1 When you get these services from doctors in your plan’s network, you don’t have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care
What’s the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That’s preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what’s causing them. That’s diagnostic care.

Child preventive care

Preventive physical exams

Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Counseling for those ages 10–24, with fair skin, about ways to lower their risk for skin cancer
- Screening and behavioral counseling for tobacco use
- Vision screening2 when done as part of a preventive care visit
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chickenpox)

Women’s preventive care

- Well-woman visits
- Breast cancer, including exam, mammogram, and genetic testing for BRCA 1 and BRCA 2 when certain criteria are met3
- Breast-feeding: primary care intervention to promote breast-feeding support, supplies and counseling (female)4,5,6
- Contraceptive (birth control) counseling
- FDA-approved contraceptive medical services provided by a doctor, including sterilization
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening5
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV5
- Pelvic exam and Pap test, including screening for cervical cancer

The preventive care services listed are recommendations as a result of the Affordable Care Act (ACA, or health care reform law). The services listed may not be right for every person. Ask your doctor what’s right for you, based on your age and health condition(s).

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the provisions of the group policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions and Limitations.

181200MUMENEMVPP2/4/16
Adult preventive care

Preventive physical exams

Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and CT colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test for vision
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years
- Screening and counseling for obesity
- Prostate cancer, including digital rectal exam and PSA test
- Sexually transmitted infections: related screening and counseling
- Screening and behavioral counseling for tobacco use
- Violence, interpersonal and domestic: related screening and counseling

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- Measles, mumps and rubella (MMR)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)
- Zoster (shingles) for those 60 years and older

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1. The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your Certificate of Coverage or call the Customer Care number on your ID card.

2. Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

3. Check your medical policy for details.

4. Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.

5. This benefit also applies to those younger than 12.

6. Counseling services for breast-feeding (lactation) can be provided or supported by an in-network (participating) provider such as a pediatrician, ob-gyn, family medicine doctor, and hospitals with no member cost-share expense (deductible, copay, coinsurance). Contact the provider to determine if lactation counseling services are available.

7. You may be required to get prior authorization for these services.

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Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Anthem Blue Cross and Blue Shield is the trade name of Blue Cross and Blue Shield of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Mississippi: Anthem Blue Cross and Blue Shield of Mississippi; in Missouri (excluding 30 counties in the Kansas City area): Hightower Managed Care, Inc. (HTM); Healthy Alliance Life Insurance Company (HALIC); and HMO Missouri, Inc. RIT and certain affiliate administrators non-HMO benefits, and all HMO benefits, are underwritten by HMO Missouri, Inc. RIT and certain affiliate administrators only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., d/b/a HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the town of Manassas, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), which underwrites or administers the POS and indemnity policies; Compcare Health Services Insurance Corporation (Compcare), which underwrites or administers the HMO policies; and Compcare and BCBSWI collectively, which underwrite or administer the PPO policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.
Don’t let an injury or sudden health issue derail your life

A hospital stay or long-term health problem can turn your life upside down. You may need to make some tough choices. And you may feel overwhelmed with new information and not sure where to get help and support.

That’s why we have a team of registered nurses, supported by clinical experts, who are trained to help during these stressful times. They’re called nurse care managers, and they are your health care advocates. Their goal is to understand your needs from all angles and help you get the best care possible.

For instance, depending on your needs, a nurse care manager might help you:

- Find out more about your health issue and your treatment options.
- Talk with your doctors and the rest of your health care team—and encourage them to talk with each other.
- Review your health plan to help you save money and get the most value from your plan.
- Connect with resources near you, like home care services and community health programs.
- Take steps to make healthy changes in your life.

Your nurse care manager will probably call you

But if you don’t pick up or need someone to help right away, you can call the number on the back of your card and ask for case management.
Nearly 9 out of 10 members who use this service say they’re “very satisfied” and would recommend the program to another member.*

*2014 member satisfaction study.

If you choose to use this free service, you’ll work one-on-one with your primary nurse care manager.

Keep in mind that the nurse doesn’t provide hands-on care to you. It’s up to your doctors and the rest of your health care team to do that. But the nurse can work with you and your team to keep the focus where it belongs: helping you manage your health and feel better. Here’s how it works:

- **Get started.** In most cases, someone from this program contacts you directly. You can also call the customer service number on your member ID card or the health benefits team where you work. Ask to get in touch with the Anthem case management team. Your nurse will call you and get to know you. You’ll talk about your current health situation and how it affects you. But you’ll also talk about your health goals — and how your nurse can help you reach them.

- **Stay in touch.** Your nurse will call you regularly to see how you’re doing and to offer support with any health issues. This is important because your needs may change over time. You’ll also have your nurse’s direct phone number, so you can call if any questions or problems come up.

- **Get better.** If you don’t think you need help anymore, just let your nurse know. You can stop participating at any time.

This service is part of your health plan and is at no added cost to you.

For information about other member programs available to you, visit our website at anthem.com.
Health concerns can happen when you least expect them. You might be on vacation or even on a business trip. Or your child may have a fever in the middle of the night. But there’s somewhere you can turn for help any time of the day or night.

Call the 24/7 NurseLine to talk with a registered nurse about your health concern. Whether it’s a question about allergies, fever, types of preventive care or any other topic, nurses are always there to provide support and peace of mind. And, if you want, a nurse will call you later to see how you’re doing.

Our nurses can help you choose the right place for care if your doctor isn’t available and you aren’t sure what to do. Do you need to head straight to the emergency room? Is urgent care best? Or do you need to see your doctor? Making the right call can save you time and money – and give you access to the best possible care.

Do you speak Spanish or another language other than English? We have Spanish-speaking nurses and translators on call. TTY/TDD services are available, too.

If you’d prefer not to talk about your health concern over the phone, the AudioHealth Library might be for you. These helpful prerecorded messages cover more than 300 health topics in English and Spanish. Just call the 24/7 NurseLine number and choose the AudioHealth Library option.

Health questions?

24/7 NurseLine is always here for you. Call toll free at 888-279-5449.

85% of members like you would recommend 24/7 NurseLine to others.
LiveHealth Online

Quick and easy access to a doctor 24/7

Have you ever been at work and didn’t feel well? Maybe you had a fever or a sore throat but you didn’t have time to leave and see your doctor or go to urgent care. Now, with LiveHealth Online, you can see a board-certified doctor in minutes.

Just use your smartphone, tablet or computer with a webcam. It’s so convenient, almost 90% of people who’ve used it feel they saved two hours or more and would use it again in the future. Plus, online visits using LiveHealth Online are already part of your Anthem Blue Cross and Blue Shield benefits. To start using LiveHealth Online, all you need to do is sign up at livehealthonline.com or download the app.

Sign up for free today and get:

1. **24/7 access to doctors.** They can assess your condition, provide treatment options and even send a prescription to the pharmacy of your choice, if needed. It’s a great way to get care when your doctor isn’t available.

2. **Medical care when you need it.** For things like the flu, a cold, sinus infection, pink eye, rashes, fever and more.

3. **Convenience.** Since there are no appointments or long waits. In fact, most people are connected to a doctor in about 10 minutes or less.

Doctors using LiveHealth Online typically charge $49 or less per visit, depending on your health plan.

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LiveHealth Online Psychology

An easy, convenient way to see a therapist or psychologist in just a few days

If you’re feeling stressed, worried, or having a tough time, you can talk to a licensed psychologist or therapist through video using LiveHealth Online Psychology. It’s easy to use, private and, in most cases, you can see a therapist within four days or less. All you have to do is sign up at livehealthonline.com or download the app to get started. The cost is similar to what you’d pay for an office therapy visit.

**Make your first appointment — when it’s easy for you**

- Use the app or go to livehealthonline.com and log in. Select LiveHealth Online Psychology and choose the therapist you’d like to see.
- Or, call LiveHealth Online at 1-844-784-8409 from 7 a.m. to 11 p.m.
- You’ll get an email confirming your appointment.
LiveHealth Online: what you need to know

What kind of doctors can you see on LiveHealth Online?

Doctors on LiveHealth Online are:

- Board certified with an average of 15 years of practicing medicine
- Mainly primary care physicians
- Specially trained for online visits

When can you use LiveHealth Online?

LiveHealth Online is a great option for care when your own doctor isn’t available and more convenient than a trip to the urgent care. With LiveHealth Online, you can receive medical care for things like:

- Cold and flu symptoms, such as a cough, fever and headaches
- Allergies
- Sinus infections and more

How do I pay for an online visit using LiveHealth Online?

LiveHealth Online accepts Visa, MasterCard and Discover cards as payment for an online doctor visit. Keep in mind that charges for prescriptions aren’t included in the cost of your doctor visit.

LiveHealth Online Psychology

What conditions can be treated when you have a visit with a psychologist or therapist?

You can get help for these types of conditions:

- Stress
- Anxiety
- Depression
- Family or relationship issues
- Grief
- Panic attacks
- Stress from coping with a sickness

How much does a therapist visit cost?

The cost should be similar to what you’d pay for an office therapy visit, depending on your benefits, copay or coinsurance. You’ll see what you owe before you start a visit and any cost is charged to your credit card. The cost is the same no matter when you have the visit — whether it’s a weekday, the weekend, evening or a holiday.

How do I decide which therapist to see?

After you log in at livehealthonline.com or with the app, select LiveHealth Online Psychology. Next, you can read profiles of therapists and psychologists. Once you select the one you would like to see, schedule a visit online or by phone. At the end of the first visit, you can set up future visits with the same therapist if both of you feel it’s needed. You always have the choice of the therapist you want to see.

What else do I need to know about LiveHealth Online Psychology?

- You must be at least 18 years old to see a therapist online and have your own LiveHealth Online account.
- Psychologists and therapists using LiveHealth Online do not prescribe medications.
- Visits usually last about 45 minutes.

Get started today

It’s quick and easy to sign up for LiveHealth Online. Just go to livehealthonline.com or download the mobile app at Google Play™ or the App Store™.
It’s quick, easy and private

If you’re feeling stressed, worried, or having a tough time, you may want someone to talk to. Now, you can use your employee assistance program (EAP) to have a video visit with a licensed therapist using LiveHealth Online. Talk with a therapist from your home or wherever you have Internet access and privacy.

Scheduling a visit is easy. In most cases, you can make an appointment to see a therapist within four days or less.* This may be sooner than waiting for an office visit.

Counselors on LiveHealth Online can help you with:

- Stress
- Anxiety
- Depression
- Relationship or family issues
- Grief
- Panic attacks

Make your first appointment — when it’s easy for you:

- Give your EAP a call at 800-223-7723 and ask about therapy visits.
- The EAP representative will tell you more about therapy options, including video visits using LiveHealth Online on your computer, smartphone or tablet.
- If video visits are right for you, the EAP representative will give you details about how to schedule a visit as well as a special coupon code.
- You can review a therapist’s background and qualifications and choose one who’s available and right for you.
- You’ll receive a confirmation email once you’ve scheduled a visit.

A few more details

Private therapy visits using LiveHealth Online are free with your EAP. Your EAP can tell you how many you’re eligible for.

Your visit will last about 45 minutes and you can set up a future visit if you need one. Keep in mind therapists do not prescribe medication.

* Appointments subject to availability of a therapist.

Ask your EAP for a coupon code for FREE online therapy visits with LiveHealth Online.
Feel your best
ConditionCare

Let our health professionals help you live your best life

Do you or a covered family member have a long-term (chronic) health problem? ConditionCare is a program for you and there’s no extra cost for you to join.

When you join ConditionCare, you’ll get:
- 24-hour, toll-free access to a nurse who’ll answer your questions.
- A health assessment by phone.
- Support from nurse care managers, pharmacists, dietitians, doctors and other health care professionals to help you reach your health goals.
- Educational guides, newsletters and tools to help you learn more about your condition.

ConditionCare nurse care managers work with members of all ages who have:
- Asthma.
- Diabetes.
- Chronic obstructive pulmonary disease (COPD).
- Heart failure.
- Coronary artery disease.

We may call to find out if ConditionCare can help you and ask you to sign up. To protect you, we’ll verify your address or date of birth before talking about your health. ConditionCare is for the whole family, so we can help parents manage their children’s chronic conditions, too.

Get help taking care of your health
To learn more or to join ConditionCare, call us toll free at 888-279-5449.
Anthem’s cancer resources
Support throughout your health care journey with cancer

Wondering what you can do to prevent cancer? Have you or someone you love been told you have cancer? A cancer diagnosis can be scary. It can create confusion and disrupt your life and the lives of your loved ones. You may have questions such as:

- What treatment do I need?
- Who provides the right treatment?
- What will my life be like having cancer?
- When will I feel better?

That’s why we’re here to partner with you to support cancer prevention or through your cancer journey by offering helpful resources and services. As a member you have access to a large network of providers and centers specializing in cancer treatment.

**How can I find cancer resources and programs?**

For more information about Anthem’s cancer resources, go to anthem.com. Select the Health and Wellness tab on the top of the webpage. Here you’ll find information on prevention and wellness topics including:

- **Case management services**
  Case management gives you access to a licensed health professional who offers support, education and resources from diagnosis through treatment and recovery. Your policy has a benefit for case management services. Case management is provided by a licensed health professional, often an RN, who can help you and your family:
  - Understand how your benefits will support treatment and medications.
  - Understand what questions to ask and how to best work with your doctor.
  - Know what to expect during the treatment and post-treatment process.
  - Navigate the insurance system, as needed.
  - Identify resources and support where you live.

**Post-treatment** – While most members move through their cancer treatment and into a cancer-free life, sometimes they must deal with end-of-life issues. We can help with both of these paths. Our services include Journey Forward, a program designed to improve the long-term health of cancer survivors. We also provide hospice benefits and end-of-life care for members facing a terminal illness.

Contact us today if you are interested in Case Management services. You can use the customer service e-mail through your registered account at anthem.com, call the customer service number on the back your ID card or we may contact you.

**Prevention, screenings, vaccines and wellness** – Diet, lifestyle and prevention are important to promote optimal health. Cancer prevention screenings are important, which is why we cover a variety of cancer screenings.

**Diagnosis and treatment** – For those who have been told they have cancer or going through cancer treatment, we offer programs including: Case Management, Employee Assistance (if available) and the Help for Caregivers online resource.

**Having cancer doesn’t mean you’re on your own. We’re here to support you and your health.**
Getting care when you need it now

Did you know you have more choices than just the emergency room (ER)?

ER wait times are at an all-time high.¹ And it can cost you more out-of-pocket. What do you do when you need care right away, but it's not an emergency? You have choices.

Many health problems need to be taken care of right away but aren't true emergencies. When you can't see your primary care doctor, you can still get care without visiting the ER. Retail health clinics, walk-in doctor's offices and urgent care centers can take less time and cost about the same as a regular doctor visit. Plus, most are open weeknights and weekends.

**Retail health clinic** — A clinic staffed by medical professionals who provide basic medical services to “walk-in” patients. Usually in a major pharmacy or retail store.

**Walk-in doctor's office** — A doctor’s office where you don't already have to be a patient or have an appointment. Can handle routine care and common family illnesses.

**Urgent care center** — Doctors who treat illnesses or injuries that should be looked at right away but aren't emergencies. Can often do x-rays, lab tests and stitches.

*For an easy-to-read chart about these options, see the other side of this flier.*

To find out where you can get care quickly while saving time and money, go to anthem.com/eralt/in/.

Before you go

Call the office or clinic and ask:
- What are your hours?
- Do you have the services I need?
- Will this be covered by my plan?

**Average cost**

<table>
<thead>
<tr>
<th></th>
<th>$800*</th>
<th>Retail — $80*</th>
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<tbody>
<tr>
<td>ER visit</td>
<td></td>
<td>Doctor's office visit</td>
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<tr>
<td>Urgent care center</td>
<td></td>
<td>Urgent care center</td>
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</tbody>
</table>

*Deductibles and coinsurance apply.

**Emergency room rule of thumb**

Call 911 or go to the emergency room if you think you could put your health at serious risk by delaying care.

Want more information on ER alternatives?

1. Call our 24/7 NurseLine at 888-279-5449.
2. If you don’t have access to the 24/7 NurseLine, you can find a retail health clinic, walk-in doctor's office or urgent care center near you by visiting anthem.com/eralt/in/. Or go online for an easy way to find ER alternatives in your state. Search Google, Yahoo! or Bing by typing “Anthem IN Urgent Care.”

¹ Centers for Disease Control and Prevention, National Hospital Ambulatory Medical Care Survey, August 2008.
If you need care right away, the ER can be crowded and may cost more. If it’s not a medical emergency, try the other choices.

Deciding where to go when you need care right away

<table>
<thead>
<tr>
<th>Who usually provides care</th>
<th>Sprains, strains</th>
<th>Animal bites</th>
<th>X-rays</th>
<th>Stitches</th>
<th>Mild asthma</th>
<th>Minor headaches</th>
<th>Back pain</th>
<th>Nasal, vomiting, diarrhea</th>
<th>Minor allergic reactions</th>
<th>Coughs, sore throat</th>
<th>Scrapes, cuts, scrapes</th>
<th>Rashes, minor burns</th>
<th>Minor fevers, colds</th>
<th>Ear or sinus pain</th>
<th>Spraying with ventilation, first aid or other</th>
<th>Vaccinations</th>
<th>Average Cost</th>
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<tbody>
<tr>
<td>Retail Health clinic</td>
<td>Physician assistant or nurse practitioner</td>
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<td>$10 — $40*</td>
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<tr>
<td>Walk-in doctor’s office</td>
<td>Family practice doctor</td>
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<td>$10 — $40*</td>
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<tr>
<td>Urgent Care Center</td>
<td>Internal medicine, family practice, pediatric and ER doctors</td>
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*DEDUCTIBLES AND COINSURANCE APPLY.

Each clinic or center may have different services available. Be sure to call and ask before you go.

Let a nurse help you decide

1. Call our 24/7 NurseLineSM at 888-279-5449.
2. A nurse will help you decide which type of care makes the most sense.

Wondering where to go?

To find a doctor’s office or clinic near you, go to anthem.com/eralt/in/ or call Customer Service at the number on the back of your ID card. (Customer Service business hours may vary.)

At Anthem Blue Cross and Blue Shield, we’re always looking for new ways to save you time and money, and help you get more value from your health care.
Having a healthy baby is every mom’s goal. And it starts with a healthy pregnancy. You want to make the right choices and take care of yourself so you can reach that goal. But it’s not always easy to do it alone.

That’s why there’s Future Moms. It’s a program that can answer your questions, help you make good choices and follow your health care provider’s plan of care. And it can help you have a safe delivery and a healthy child.

Sign up as soon as you know you’re pregnant. Just call us toll free at 888-279-5449. One of our registered nurses will help you get started. You’ll get:

- A toll-free number you can use to talk to a nurse coach any time, any day, about your pregnancy. A nurse may also call you from time to time to see how you’re doing.
- A book that shows changes you can expect for you and your baby during the next nine months.
- A screening to check your health risk for depression or early delivery.
- Other useful tools to help you, your doctor and your Future Moms nurse keep track of your pregnancy and help you make healthier choices.
- Free phone calls with pharmacists, nutritionists and other specialists, if needed.
- A booklet with tips to help keep you and your new baby safe and well.
- Other helpful information on labor and delivery, including options and how to prepare.

It’s easy to join

Sign up for Future Moms by calling us toll free at 888-279-5449. There’s no extra cost to you.
State Employees
Health • Prescription • Dental • Vision

Invest In Your Health

Contact State Personnel Benefits

in.gov/spd/openenrollment
in.gov/spd/benefits

SPDBenefitsspd.in.gov

(317) 232-1167 - Indianapolis area
1-877-248-0007 - toll-free outside Indianapolis

@INSPDBenefits on Twitter