Welcome to 2022 Open Enrollment! This presentation will cover important deadlines and information about the many benefits available to you as a State Employees.
Don’t Miss It!

Wednesday, Oct. 27th
to
Wednesday, Nov. 17th at noon EST

All elections and changes must be done through PeopleSoft by the deadline!

Each year employees can make new benefit elections or change their benefits during open enrollment.

The choices you make lock you into your benefits for the next year unless you have a qualifying event (more on this in a few slides). It’s worth it to spend some time getting familiar with your options.

This year open enrollment opens Wednesday, October 27th and ends Wednesday, November 17th at noon.

During this time, you can use PeopleSoft to enroll in coverage or make changes. Any changes you make to medical, dental, vision coverage in open enrollment are for Jan 1, 2022.
Know the Lingo

| Premium | The amount you pay for your insurance coverage
|         | This is deducted from each bi-weekly paycheck |
| Allowed Amount | A discounted rate for services that the provider has agreed to |
| Deductible | The amount you must pay before your health plan pays anything
| Co-Insurance | Your share of the allowed amount after the deductible is met. |
| Out-of-Pocket Maximum | The maximum amount of deductible + co-insurance you will have to pay. Once your maximum out-of-pocket is met, the plan pays 100% of the allowed amount. |
| Maximum Exposure | The maximum amount you would pay for health insurance in a year where you meet your out-of-pocket maximum
|         | Annual Premium + Out-of-Pocket Max – HSA Employer Amount |

Before we jump in, we’re going to spend a few minutes going over some key terms that are used in insurance and benefits. A lot of this lingo is specific to insurance and not things that we use every day. Understanding these terms will help you to understand the options being offered to you.

1. **Premium** – this is the amount that you pay for insurance. The premiums for the options you select will be deducted from each bi-weekly paycheck.

2. **Allowed Amount** – this is the discounted rate that in-network providers have agreed to. Going to in-network providers saves you money. Even when staying in-network, it pays to shop around since some in-network providers have agreed to bigger discounts than other in-network providers.

3. **Deductible** – all of the health plans have a deductible. This is the amount that you must pay before the health plan starts paying for services.

4. **Co-insurance** – AFTER the deductible is met – the plan starts paying for services. The co-insurance amount shows how much you pay and how much the plan will pay for services.

5. **Out-of-pocket max** – This is the maximum you will pay for services in the year if you go to in-network providers. Once you have met your deductible and paid enough in co-insurance to get to the OOP max, the plan will pay 100% of the allowed amount for services.

6. **Maximum exposure** – this is a helpful figure to see how much your health insurance costs when you meet your out-of-pocket max. Your max exposure is the premiums you’ve paid plus the OOP max minus any HSA contributions you received from the state.
Health Savings Account, or HSA, is a special bank account that allows employees and employers to make tax-free contributions. HSAs can only be used with high-deductible health plans and can only be used to pay for medical expenses outlined by the IRS.

Eligible dependents are persons that can be enrolled in family benefit options. This includes your spouse, children, step-children, foster children, legally adopted children and children whom you have legal custody of. Children are eligible for coverage until age 26 and will be removed at the end of the month in which they turn 26. Disabled children may continue coverage beyond age 26 if they meet the requirements.

A qualifying event is a life event that allows you to make changes to your benefits. Some examples are change in marital status, birth or loss of a dependent, and changes in employment status. Remember – most elections you make at open enrollment cannot be changed unless there is a qualifying event due to federal regulations.
What’s the same

- Employee premiums – 3rd year in a row!
- Employer HSA contribution
- Three medical plan options to choose from
- Medical, dental and vision plans continue to be administered by Anthem

We’re going to start with a quick overview of what’s the same and what’s different before getting into the details.

First – what’s the same:

- For the 3rd year in a row, employee premiums will be the same. The premium is the amount you pay for medical, vision and dental coverage.

- The amount the state puts into HSA accounts on your behalf is also staying the same.

- We are continuing to offer three medical plans – CDHP1, CDHP2 and the Traditional plan.

- Anthem will continue to be the vendor administering the medical, dental and vision plans.
What’s new

- Spouse and child dependent life insurance no longer have to be the same coverage amount
- Optum is the new EAP vendor starting Jan 1 (EAP = Employee Assistance Program)
- In-network providers are being split into tiers
  Tier 1 HealthSync: lowest cost option
  Tier 2 In-Network: all other in-network providers

Now for the changes:

- In the past, when you chose life insurance for both your spouse and a child or children, you’ve had to pick the same coverage amount as a bundled option. New this year, spouse and child coverage is unbundled so you can choose different coverage amounts. If you already have bundled dependent life insurance coverage, the spouse and child coverage will be separated automatically in your open enrollment event in PeopleSoft.

- Coming in January, we’ll be switching our EAP vendor to Optum which will allow for helpful new features like being able to schedule EAP services online and a text-therapy option. You will continue to have eight free EAP services, either face-to-face with a provider or virtually.

- This last change is a big one that we’ll be spending some time explaining.
  - New for 2022, we are splitting our current in-network providers into two tiers.
  - Tier 1 is preferred in-network providers with the best prices for hospital services. Tier 2 is all other in-network providers.
• The Tier 1 providers are all part of Anthem’s HealthSync program. They have agreed to **lower hospital costs** and are focused on **proactively managing patient health**. This tier has the best deductible and out-of-pocket so the plan starts paying for services sooner.

• Tier 2 providers are still in-network providers and a good option. Their costs are **similar to what you experience today**.

• Out-of-network providers are the most expensive option. They have not agreed to a visit cost so there is **no limit to what you can be billed**.

You’ll still be able to use any providers you want, and you don’t have to designate a provider during open enrollment.

You can use a mix of tier 1, tier 2 and out-of-network providers if you’d like to.

The same services are covered at all providers, but the price you pay for those services will be different if they are Tier 1 versus Tier 2.

It is all about choice and helping you to find the lowest cost provider options.
Tier 1 HealthSync includes over 65 hospitals and 25,000 providers throughout the state. HealthSync includes all Ascension/St. Vincent and Franciscan/St. Francis providers.

Prior to Jan 1, you will use a guest log-in to search for providers. This can be found on the Open Enrollment website: www.in.gov/spd/openenrollment/

After Jan 1, your Anthem info, either at Anthem.com or in Anthem’s Sydney app will integrate the tiers into the Find Cost & Care tool.
For now, here is what a search for the provider’s tier will be.

After searching for a provider, select the “Recognitions/Tiers” link.

A box will pop-up showing the provider Tier and any other recognitions that provider has. You may need to scroll through the recognitions to find the tier.

This is an example of a hospital search where the provider is tier 1.
We’ll do the same thing on this provider – select the “Recognitions/Tiers” link.

This hospital is Tier 2.
We’ve talked about how the provider tier can impact your bill.

The place you go for care can also impact what you pay.

While we’re all familiar with the ER, you may not know that it is 11x the cost of an urgent care visit.

Most primary care offices now have after-hours triage numbers to help you decide if you need to go to the ER, urgent care, or if it can wait until the office opens the next day.

The Anthem nurseline provides the same service 24/7.

Being choosy about where you go is one more way to save.

Next, we’re going to talk about the health plan options for 2022.
## Compare the plans

<table>
<thead>
<tr>
<th>Different for All Options</th>
<th>Same for All Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium amount</td>
<td>Services covered</td>
</tr>
<tr>
<td>Deductible, Co-insurance &amp; Out-of-Pocket Maximum</td>
<td>Prescription drug coverage levels</td>
</tr>
<tr>
<td>HSA contribution</td>
<td>Wellness program and rewards</td>
</tr>
<tr>
<td></td>
<td>Provider options</td>
</tr>
</tbody>
</table>

It’s important to keep in mind that the only differences in the three health plan options are:

1. The premium that you’ll pay each paycheck
2. The deductible, coinsurance and out-of-pocket maximums – these three things are known as “cost sharing”
3. And the HSA contribution made by the state

Each health plan option:
- covers the exact same services,
- has the same prescription drug benefits,
- has the same wellness program with rewards,
- and the same provider options.

Your big decision is which premium and cost-sharing combo is right for you.
The three health plan options are very familiar if you know what we have today.

The consumer driven health plan 1, or CDHP1, is a high deductible health plan with an HSA.

The consumer driven health plan 2, or CDHP2, is a second high deductible with HSA option.

The Traditional plan, or Trad, has a traditional deductible and is not HSA eligible.

We’re going to do a deep dive into CDHP1 since it is the most popular plan. Then we’ll circle back to look at the CDHP2 and Trad plans.
This is a snapshot of the CDHP1.

Tier 2—it is very familiar to what you have today.

The Tier 2 deductible, OOP max, premiums and HSA are staying the same.

New for 2022 is the Tier 1 HealthSync column. When you go to Tier 1 HealthSync providers, you’ll have a lower deductible, OOP, and coinsurance rates.

No matter which tier the provider is in, the amount you pay is applied to the deductible and OOP max of all three tiers. The Tier 1, Tier 2 and OON are not separate deductibles.

I know this could sound confusing – but stick with me. We’re going to go through an example next to show you how it all works.
How it Works

What’s the service?
What’s the provider’s tier?
How much have you spent so far?
Add up deductible & coinsurance due

An example using CDHP1 Single

The example looks at four visits.

These are the steps to go through with each visit claim to figure out how the tiers work together.

1. First – consider the service.
2. Next – verify the provider tier and get the estimated cost.
3. Then – check how much has been spent so far in the year.
4. Finally – add up what’s due and evaluate where you’re at in your deductible and OOP for the year.
For our example, we are assuming it is the beginning of the year and this is the first visit.

This employee needs a specialist visit.

The employee was able to find a Tier 1 provider. **That’s great since Tier 1 providers have a lower deductible.** This visit costs $100.

Since it is the beginning of the year, the employee has not spent anything yet and no deductibles have been met.

For this visit, the employee will pay $100 towards their deductible. For all these examples, we’ll use the buckets on the slide to follow our deductible progress.

The $100 paid by the employee applies to both Tier 1 and Tier 2 deductibles. The Tier 1 bucket now shows $100 out of $2,000 paid. The Tier 2 bucket now shows $100 out of $2,500 paid. This is called cross-accumulating. Whenever you have a Tier 1 or Tier 2 claim, the amount you pay will always cross-accumulate to both tiers.
What’s the service? Urgent Care Visit

What’s the provider’s tier? Tier 2: $215

How much have you spent so far? $100

You pay $215 towards your deductible

$215 goes towards both your Tier 1 and Tier 2 deductibles

Total paid so far: $315

Moving on to the next visit of the year.

This time it is an urgent care visit.

The employee ended up at a Tier 2 urgent care and the cost was $215.

We’re carrying over the amount spent so far from the last slide – that’s our $100 for the specialist visit we just went through.
No deductible has been met yet.

For this visit, the employee will pay $215 towards their deductible.

Even though this is a Tier 2 provider – again everything cross-accumulates – so the $215 gets applied to both the Tier 1 and Tier 2 buckets.
We’re now at:
Tier 1 bucket showing $315 out of $2,000 paid.
Tier 2 bucket showing $315 out of $2,500 paid.
What’s the service?  Biopsy Procedure
What’s the provider’s tier? Tier 1: $3,400
How much have you spent so far? $315
You pay $1,856.50 in deductible & coinsurance

$1,685 to meet deductible
$171.50 in coinsurance (10%)
$1,856.50 is applied

Total paid so far: $2,171.50

The employee’s third visit of the year is for a biopsy.

The employee is seeing a Tier 1 provider – since this is a higher cost outpatient surgery procedure, using a Tier 1 provider really helps on the visit cost. The visit cost is $3,400.

We’re carrying forward what we’ve spent so far on the last two visits - $315.
No deductible has been met yet – but this visit will meet the Tier 1 deductible. Let’s go through it.

Since this is a Tier 1 provider, we start by checking the Tier 1 deductible which is $2,000.
The employee will pay the first $1,685 of the visit to meet the Tier 1 deductible. We found this amount by subtracting the $315 already paid from the $2,000 deductible.

Now that the Tier 1 deductible is met – the employee is in the coinsurance phase. Coinsurance means the employee pays just 10% of the remaining visit cost.
10% applied to the remaining visit cost is $171.50.
The total paid by the employee for this visit is $1,856.50.

Again - everything cross-accumulates – so this amount gets applied to both the Tier 1 and Tier 2 buckets.
The total spent for the year of $2,171.50 is in both buckets.
The Tier 1 deductible is now met so all Tier 1 visits will be at the coinsurance until the OOP max is reached.
But ... the Tier 2 deductible is not met yet.
The fourth, and final, example is a CT Scan with a Tier 2 provider for $450.

On the previous slide, the spending for the year was at $2,171.50.
Since this is a Tier 2 provider, check the Tier 2 deductible to see if it has been met.
It has not been met.

The employee will pay the first $328.50 of the visit to meet the Tier 2 deductible. We found this amount by subtracting the $2,171.50 already paid from the $2,500 Tier 2 deductible.
Now that the Tier 2 deductible is met – the employee is in the coinsurance phase. The Tier 2 coinsurance is 30%. The employee pays 30% of the remaining visit cost.
30% applied to the remaining visit cost is $36.45.

Both deductibles are met. The next visit cost will be based on the provider tier that is chosen. Choosing Tier 1 providers will provide savings on the visit cost.
Remember

Anytime you use a Tier 1 provider, you’re saving money!

Want to ask about your specific situation?
Contact the Benefits Hotline
877-248-0007 or SPDBenefits@spd.in.gov

There was a lot of new information packed into that example. It’s a new concept for many and it may take some time to become a pro. The key thing to remember is anytime you use a Tier 1 provider, you are saving money through lower hospital costs and better cost-sharing.

Want to ask questions about your specific situation or go through the example with a Benefits Specialist? Contact the Benefits Hotline at 877-248-0007 or SPDBenefits@spd.in.gov.
<table>
<thead>
<tr>
<th>CDHP2</th>
<th>Tier 1</th>
<th>Tier 2 In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HealthSync</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$1,400</td>
<td>$1,750</td>
<td>$1,750</td>
</tr>
<tr>
<td>Family</td>
<td>$2,800</td>
<td>$3,500</td>
<td>$3,500</td>
</tr>
<tr>
<td>Out-of-Pocket Max</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$2,500</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$5,000</td>
<td>$6,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Co-Insurance Rate</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Office Visit</td>
<td>10%</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>10%</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>10%</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Bi-weekly Premium</td>
<td>Single $32.50-$81.90</td>
<td>Family $108.34-$186.54</td>
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<tr>
<td>Annual HSA Amount</td>
<td>$787.80</td>
<td>$1,575.60</td>
<td></td>
</tr>
</tbody>
</table>

The example was assuming CDHP1 single coverage.
Here’s a chart of CDHP2.

Again, you’ll notice Tier 2 is very familiar to what you have today.

The Tier 2 deductible, OOP max, premiums and HSA are staying the same.
Tier 1 HealthSync, has a lower deductible, OOP, and coinsurance rates.
Again - No matter which tier the provider is in, the amount you pay is applied to the deductible and OOP max of all three tiers.
And here is your third and final option: the Traditional plan.

Again, Tier 2 deductible, OOP max, premiums and HSA are staying the same. Tier 1 HealthSync, has a lower deductible, OOP, and coinsurance rates.
Prescription Drug Coverage

All in-network pharmacies are Tier 1
Coinsurance rates apply after deductible

<table>
<thead>
<tr>
<th></th>
<th>Retail Pharmacy (up to 30 days)</th>
<th>Mail Order Pharmacy (up to 90 days)</th>
<th>Retail Pharmacy (up to 90 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Medicines</strong> (mandated by the ACA)</td>
<td>$0 (no deductible)</td>
<td>$0 (no deductible)</td>
<td>$0 (no deductible)</td>
</tr>
<tr>
<td><strong>Generic Medicines</strong></td>
<td>$10 copay</td>
<td>$20 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td><strong>Preferred Brand-Name Medicines</strong></td>
<td>20% Min. $30, Max. $50</td>
<td>20% Min. $60, Max. $100</td>
<td>20% Min. $90, Max. $150</td>
</tr>
<tr>
<td><strong>Non-Preferred Brand Name Medicines</strong></td>
<td>40% Min. $50, Max. $70</td>
<td>40% Min. $100, Max. $140</td>
<td>40% Min. $150, Max. $210</td>
</tr>
<tr>
<td><strong>Specialty Medicines</strong></td>
<td>40% Min. $75, Max $150 (30 day supply only)</td>
<td>40% Min. $75, Max $150 (30 day supply only)</td>
<td>40% Min. $75, Max $150 (30 day supply only)</td>
</tr>
</tbody>
</table>

All three plans have the same prescription drug coverage.

All in-network pharmacies are Tier 1 providers.
The cost sharing rates in the table start once your Tier 1 deductible is met. Before the Tier 1 deductible is met, you pay 100% of your prescription’s cost.

Prescription cost sharing is a little different than the medical side since it isn’t a straight percentage. Once you calculate the percentage, there is also a minimum and maximum. You’ll calculate the percentage, and then look at the minimum and the maximum to adjust the amount. Remember – the percentage and minimum/maximum do not kick in until that deductible is met!
Preventive Services

Qualified preventive services are at no cost to you for all provider network tiers

- Preventive physical exams, screenings and tests
- Immunizations including flu and COVID-19
- Some medications such as tobacco cessation products

Preventive care services are special.

All three plans cover preventive services at no cost to you. This means the plan covers the cost regardless if you have met your deductible or not.

Preventive care services are defined by the federal government. Some examples are your annual physical, immunizations such as the flu vaccine and COVID-19 vaccine, and some medications like tobacco cessation products.

These are all services to help prevent disease and catch problems early on.
Health Savings Accounts

You must ONLY have high deductible health plan coverage to make & receive contributions

• The state contributes 45% of the Tier 2 CDHP deductible.
• You can make contributions too!
• Funds must be used to pay for qualified medical expenses for yourself, your spouse, & your dependent children.
• The IRS regulates HSA accounts. There are penalties for using HSA funds for non-qualified medical expenses.

We talked a little about Health Savings Accounts when we were going through the insurance lingo.

The most important thing to remember is you can only have a health savings account if you have only high deductible health plan coverage. CDHP1 and CDHP2 are high deductible health plans. The Traditional plan is not a high deductible health plan. This also means you can’t have non-high deductible health plan coverage outside of your state employee coverage such as Medicare, Medicaid, Tricare, etc.

The state contributes 45% of the Tier 2 deductible into an HSA for CDHP1 and CDHP2 enrollees. Half of this money is deposited with the first payroll in January. The second half is deposited over the course of the 26 paychecks of the year.
You can also contribute through payroll deductions. This is a great way to make sure you have money set aside for medical costs AND it is pre-tax.
Any funds in the HSA must be used for qualified medical expenses for yourself, your spouse or your dependent children.

It’s important to note that the IRS regulates HSA accounts and there are penalties if you use the finds for anything other than qualified medical expenses.
Wellness Program & Rewards

Included in your medical benefits
Unlimited 1:1 health coaching
Online resources and tracking
Rewards

Enrollment in any of the three plans gives you access to wellness tools and rewards. The wellness tools include unlimited 1:1 health coaching. Everyone has access to virtual coaching and many work locations have health coaches that come onsite. Health coaches help you make small changes that have a big impact on your health.

Rewards are announced in January so be on a look out. If you are enrolled in a medical plan now, it is not too late to earn a $25 gift card for completing your health assessment by Nov 30th. If you’re not sure how to get started, give our benefits hotline a call.
How do you pick the right plan?

**CDHP1**
Lowest annual premium
Might be right if unlikely to meet deductible and/or out-of-pocket max

**CDHP2**
Lowest total exposure
Might be right if you are likely to meet your deductible and/or out-of-pocket max

**TRAD**
Lowest out-of-pocket max
Might be right if you prefer to pay a higher set amount with each paycheck to have lower visit costs
Might be right if you cannot have an HSA account

Now that we’ve been through the three health plan options and talked about some of the great services included in your medical package, we’ll spend a few minutes comparing the plans to each other.

Remember – the only thing that is different with the plans is the premium you pay, the HSA you receive, and the cost sharing which is your deductible, out-of-pocket max, and coinsurance rates.

The CDHP1 has the lowest annual premium and gives you the highest HSA, but it also has the highest deductible. This might be a good plan for you if you are unlikely to hit the out-of-pocket max. And it’s still a good option even if you end up hitting it.

The CDHP2 has a premium that’s a little higher than the CDHP1, but the deductible and out-of-pocket max are lower. This might be a good plan for you if you tend to reach your deductible or out-of-pocket max.

The traditional plan has the highest premium and no HSA. The deductible is lower, but you are paying a lot more out of your check each time for this coverage. This might be the right plan for you if you are more comfortable with a lower deductible or if you cannot have an HSA account.

Next is a chart that puts all the numbers together for you.
### How do you pick the right plan?

<table>
<thead>
<tr>
<th></th>
<th>Tier 1 HealthSync</th>
<th>Tier 2 In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CDHP1</td>
<td>CDHP2</td>
</tr>
<tr>
<td><strong>Annual Premium</strong></td>
<td>$ 880</td>
<td>$ 880</td>
</tr>
<tr>
<td>+ <strong>Out-of-Pocket Max</strong></td>
<td>$3,500</td>
<td>$4,000</td>
</tr>
<tr>
<td>- <strong>Annual HSA Amount</strong></td>
<td>($1,125)</td>
<td>($1,125)</td>
</tr>
<tr>
<td><strong>Maximum Exposure</strong></td>
<td>$3,255</td>
<td>$3,755</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Tier 1 HealthSync</th>
<th>Tier 2 In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CDHP1</td>
<td>CDHP2</td>
</tr>
<tr>
<td><strong>Annual Premium</strong></td>
<td>$2,699</td>
<td>$2,699</td>
</tr>
<tr>
<td>+ <strong>Out-of-Pocket Max</strong></td>
<td>$7,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>- <strong>Annual HSA Amount</strong></td>
<td>($2,250)</td>
<td>($2,250)</td>
</tr>
<tr>
<td><strong>Maximum Exposure</strong></td>
<td>$7,449</td>
<td>$8,449</td>
</tr>
</tbody>
</table>

There are a lot of numbers on this chart, but it is a helpful summary!

The top chart shows amounts for single coverage. The bottom chart shows the amounts for family coverage.

This chart shows you the total you would spend in health insurance and medical expenses if you reach the out-of-pocket maximum. It is the worst-case scenario and called your Maximum Exposure. It puts together the total premiums you pay plus the total medical expenses you would pay minus the HSA contributions you receive.

CDHP2 has the lowest maximum exposure when the out-of-pocket max is reached. CDHP1 premiums are significantly lower, and the Trad premiums are much higher.

This information is published on our website to refer to.
Ways to Save

Non-Tobacco Use Agreement Discount

- $35 discount on your bi-weekly premium
- Agreement to abstain from all tobacco products all of 2022 – including vaping and e-cigarette products
- Employees that select this discount may be randomly selected for testing

The premiums in the chart on the previous page were for an employee that has accepted the non-tobacco use agreement.

Each year, you can elect to commit to being tobacco free for a discount of $35 on each bi-weekly premium. When you select this option, you are agreeing to remain tobacco free for all of 2022 including vaping and e-cigarette products. Employees that select this discount may be randomly selected for testing.

If you select this option and feel you can no longer keep your commitment, you can revoke the agreement, but it must be done before you have used tobacco products and you have to repay any discount that has already been received that year.
A second way to save is by earning the wellness premium discount. This discount is earned in the current year for a discount off of next year’s premiums. Enrollees were able to select one of three activity paths in 2021 to complete by 9/30/21 for a discount off of 2022 premiums.

If you are someone who earned this discount in 2021, your discount will automatically be applied to your 2022 premiums in PeopleSoft.

Be ready for that January email that will share all the wellness rewards available to be earned in 2022.

This wraps up the information on the medical plans. We’re going to spend a few minutes going over the other benefit options. There are not many changes to these other benefits this year, so we’ll cover them quickly, but remember all this information is also available on our website.
Dental

!!! No change to coverage or cost

<table>
<thead>
<tr>
<th>Deductible</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$50 per person / $150 family max.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan Maximums</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Benefit Max.</td>
<td></td>
<td>$1,500 per person</td>
</tr>
<tr>
<td>Orthodontic Lifetime Max.</td>
<td></td>
<td>$1,500 per eligible person</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coinsurance Rate</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and Preventive</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Basic Services, Endodontics, Periodontics, Oral Surgery, Prosthetic Repairs/Adjmt.</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Major Restorative, Prosthodontics &amp; Orthodontics</td>
<td>40%</td>
<td>50%</td>
</tr>
</tbody>
</table>

| Bi-Weekly Premium        | Single $1.32 | Family $3.42 |

There are no changes to the dental plan this year. The premiums and coverage are exactly the same as current year.

This plan works similarly to the medical plans. The coinsurance rates at the bottom of the table kick in once the deductible is met.

The exception is preventive care which is no cost to you!

Dental has an annual maximum that the plan will pay. Once this maximum is met, you pay 100% of the visit costs.
Vision

No change to coverage or cost

All coverage is once per year

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Eye Exam</td>
<td>$10 copay</td>
<td>Up to $35 reimbursement</td>
</tr>
</tbody>
</table>

Choose eyeglasses or contact coverage for the year:

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyeglasses</td>
<td>$150 allowance</td>
<td>Up to $35 reimbursement</td>
</tr>
<tr>
<td>Frames</td>
<td>$25 copay</td>
<td>Up to $25-$55 reimbursement</td>
</tr>
<tr>
<td>Lenses</td>
<td>$15-$35 copay</td>
<td>No coverage</td>
</tr>
<tr>
<td>Lens enhancements</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Lenses (choose one)</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective conventional</td>
<td>$150 allowance</td>
<td>Up to $95 reimbursement</td>
</tr>
<tr>
<td>Elective disposable</td>
<td>$150 allowance</td>
<td>Up to $95 reimbursement</td>
</tr>
<tr>
<td>Non-elective (medically necessary)</td>
<td>Covered in Full</td>
<td>Up to $165 reimbursement</td>
</tr>
</tbody>
</table>

Bi-Weekly Premium

|                     | Single $.42       | Family $3.06                    |

There are no changes to the vision plan this year. The premiums and coverage are exactly the same as current year.

This plan works a little different than the medical and dental. Instead of deductibles and coinsurance, this plan works on copays and allowances.

An allowance is the maximum the plan will pay for the service.

For example, if you choose to get eyeglasses, the plan will pay up to $150 for your frames. If you select frames that are $125, the plan will pay the full cost. If you select frames that are $175, the plan will pay $150 and you would be responsible for $25 – the amount above the allowance.

Also, please note that you can use either the eyeglasses or the contact lenses benefit in the year. You cannot use both!

Maximize your allowances by visiting in-network providers.
**Life Insurance**

New employee and spouse coverage requires Evidence of Insurability (EOI)

<table>
<thead>
<tr>
<th>Basic term life and AD&amp;D</th>
<th>Additional coverage options:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 1.5x annual salary</td>
<td>• Supplemental term life</td>
</tr>
<tr>
<td>• State pays some of the cost</td>
<td>• Voluntary AD&amp;D</td>
</tr>
<tr>
<td>• Required before eligible for additional coverage options</td>
<td>• Spouse term life</td>
</tr>
<tr>
<td>• Bi-weekly cost = $0.098 per $1,000 of salary</td>
<td>• Child term life</td>
</tr>
</tbody>
</table>

You can also enroll in Voluntary AD&D or dependent child life insurance (must already have at least basic life insurance overage). Any life insurance you are currently enrolled in will continue unless you reduce or waive it.

In order to enroll in new coverage for basic, supplemental, or spouse dependent life an application called evidence of insurability must be submitted and approved prior to becoming effective. This application process does not happen in your open enrollment event in PeopleSoft and can be done anytime of the year.

Basic term life including accidental death and dismemberment covers 1.5x your annual salary. The state helps pay some of the cost of coverage. The cost is less than 10 cents per $1,000 of your salary each bi-weekly paycheck.

You must elect basic term life and AD&D to be able to elect the additional coverage options.

New for this year, you can select different coverage amounts for your spouse and child(ren) dependent life insurance coverage. If you already have spouse and child(ren) dependent life insurance coverage, the system will already have them separated for you.
Another great benefit that helps you save money is flexible spending accounts. These accounts allow you to make pre-tax contributions and must be elected each year. Your elections do not roll over from year to year!

Make sure you’ve spent some time deciding the right amount to contribute since these accounts are use it or lose it. If you do not have enough expenses incurred to get reimbursed for all the funds contributed, you lose those contributions.

The state is paying 100% of the cost of administering this benefit in 2022. There is no cost to you other than the contributions you choose to make.
## Flexible Spending Accounts

<table>
<thead>
<tr>
<th>Contribution Limits</th>
<th>Health FSA</th>
<th>Limited Purpose FSA</th>
<th>Dependent Care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,750</td>
<td>$2,750</td>
<td>$5,000</td>
</tr>
<tr>
<td>Restrictions</td>
<td>Cannot have an HSA</td>
<td>Paired with an HSA</td>
<td>Expenses incurred for dependents under 13 years old</td>
</tr>
<tr>
<td>What can be reimbursed?</td>
<td>Qualified health care expenses not covered or reimbursed by insurance</td>
<td>Before HDHP* deductible Dental, vision and preventive care After deductible Becomes a Health FSA - qualified health care expenses</td>
<td>Qualifying dependent care expenses paid to a qualified provider Does not include dependent medical expenses</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Your flexible spending account options are:

Health FSA – this is for individuals that do not have an HSA. The funds you contribute can be used to pay for qualified health care expenses that are not paid for by your insurance plans. This would be things like the visit costs you pay before you have met your deductible.

The Limited Purpose FSA is for individuals with an HSA. The funds you contribute have some restrictions before you’ve met a minimum amount of paid expenses. This is set by the IRS annually. Before this limit, you can only use the funds for dental, vision and preventive care. After the limit, it works like a Health FSA and the funds can be used for any qualified health care expenses that are not already being paid by the plan. The limit this year is $1,400 for single and $2,800 for family.

The dependent care FSA is for individuals with dependents under 13 years old that will have dependent care expenses such as daycare or before and after school care. This does not includes medical expenses.
Commuter Benefit Reimbursement Account

Allows pre-tax contributions to pay for work-related commuting expenses

• Monthly maximum contribution is $270
• This election carries over from year to year
• Eligible work-related commuting expenses are:
  - Bus
  - Monorail
  - Train
  - Ferry
  - Streetcar
  - Subway
  - Rail
  - Trolley

One more way to save – the commuter benefit reimbursement account. If you have work-related commuting expenses such as bus, train, ferry, rail or vanpool, you can contribute up to $270 pre-tax each month to be reimbursed for those expenses.

This election carries over from year to year so be sure to make any desired changes, including waiving coverage, while making your open enrollment elections in PeopleSoft.
EAP – you’re automatically enrolled!

All full-time employees and members in their household

- 8 counseling sessions – in-person or virtually
- Legal and financial consultation and referrals
- Elder and child care resources
- Stress management tools

Call Anthem EAP for services:
(800) 223-7723

And the last benefit we’ll talk about today – The Employee Assistance Program.

This is a really great benefit. You’re automatically enrolled and the state pays 100% of the costs.

EAP is available to all full-time employees plus anyone living in your household.

EAP is here to help with life events and stressors. You can receive eight free counseling sessions and also have access to resources and referrals for legal, financial, childcare, and stress.

You can use EAP right now by calling Anthem to access services.

In January, you’ll receive an email about new expanded EAP services when our EAP vendor switches from Anthem to Optum.

Look forward to easier scheduling and more options to receive help when you need it.
That wraps up this presentation, but we’re just getting started in sharing information with you.

We have a dedicated web page with everything you need to know to make the right open enrollment elections for you.

You’ll also be receiving weekly emails highlighting the different benefits and providing in depth email.

If you have questions, we’re here to help! You can reach SPD benefits through our email inbox or give us a call Monday through Friday from 7:30 a.m. to 5:00 p.m. The closer we get to the open enrollment deadline, the busier the hotline gets so call early.