

State of Indiana

Open Enrollment 2012

A guide to making your best choice



State Employees

Health • Prescription • Dental • Vision

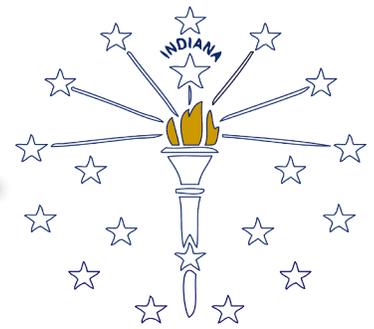


Table of Contents



Introduction	3
What's new in 2012?	4
A guide to a successful Open Enrollment	5
Education sessions	6
Effective dates	7
Non-tobacco use incentive	7
Health plans for 2012	
Summary of plans and rates	8
CDHP1 summary	9
CDHP2 summary	11
Traditional PPO summary	13
Health Savings Accounts	14
Tower Bank HSA Enrollment Packet	15
Additional benefits	
Medco prescription coverage	20
Dental plan and rates	21
Vision plan and rates	23
Flexible Spending Accounts	25
Life insurance	26
Notices	
Eligibility requirements to enroll.....	27
Qualifying events	27
Dual coverage	28
Creditable Coverage Disclosure Notice for Plan Year 2012	28
Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).....	28
Women's Health and Cancer Rights Act (WHCRA) of 1998.....	29
Open Enrollment help	
Completing your open enrollment starting Oct. 31.....	29
Making the most of your health plan	
360 Health and 24/7 NurseLine	30
Employee Assistance Program (EAP), ConditionCare and MyHealth@Anthem	31
Explanation of Benefits Reference Guide	32
Anthem Care Comparison	34
MyHealth@Anthem	35
MyHealth Record	37
Wellness Exams	39
Carrier contact information	41
Glossary	42

Open Enrollment 2012



State Employees

Our annual open enrollment period provides an opportunity to communicate important plan changes, provide new or updated information and legally required notices. Most of us admittedly focus on the cost – “How much?” And then we ask, “Why?”

“HOW MUCH?”

We have an idea of the cost – the rates have been published, so have the premiums, deductibles and out-of-pocket maximums. Now we need to determine which plan best fits our personal health care and financial needs in order to realize the true cost.

There are a number of tools on the Open Enrollment website to help you make an informed decision. For instance, review the plan summaries to get a better understanding of what is considered a covered expense and what is not. Learn about in-network vs. out-of-network providers. Review the examples and substitute your personal information so you can get a better idea of what your costs would be. And don’t forget to use the Benefits Calculator.

All these tools and more are there for you to make the best informed decisions for you and your family’s health care needs for 2012.

“WHY?”

We all ask this question, “Why do rates keep rising?” There seems to be no cap on health care inflation. Part of the reason is that we are aging. And as we age, many of us need more care than we did at our younger ages.

Technology has made life simpler for many of us, but it comes at a cost. Health care tools and treatments are more advanced today and therefore, are more expensive.

What stays the same in 2012?

- State will continue to front-load 50% of the HSA contribution in January
- Delta Dental and Anthem will continue to administer dental and medical plans
- No increase in cost of vision or life insurance plans
- State continues to pick up more than 75% of total healthcare costs – better than the 70% employer average

A study conducted by the Institute of Medicine of the National Academies revealed these startling facts: “If other prices had grown as quickly as healthcare costs since 1945...

- A dozen eggs would cost \$55
- A gallon of milk would cost \$48
- A dozen oranges would cost \$134.”

While it is comforting that we do not pay those prices, if we did have to pay them, wouldn’t we think first before doing so? We would look at our options and determine where to spend our money. That is what we should do in light of today’s healthcare costs. It might be easier to run to the emergency room for treatment, but the cost of that is almost always significantly higher than a doctor’s visit or a trip to a walk-in clinic.

Since preventive measures are covered 100% by our health plans, take advantage of them. Prevention is one of the greatest defenses against health issues. Prevention includes making healthier eating habits, adding exercise into our lives and getting those screenings, annual exams and vaccinations.

During 2012, the state will be focusing on helping us to become healthier. There are plans to pilot an onsite clinic, where employees can receive treatment for minor issues and fill prescriptions. A wellness program will be launched whereby employees will be rewarded for their participation. And a transparency portal will allow employees an inside look into costs of services and treatments and then make an intentional decision on how best to spend our health care dollars.

The bottom line is that together, state and employee, we work to improve our health holistically. By doing so, we will be another step closer to being a more efficient workforce.

What's new in 2012?

The state will offer three Anthem plans again in 2012: two consumer-driven plans (CDHPs) and one Traditional PPO (Trad PPO). For those employees still on the Trad PPO plan, the two CDHPs offer an automatic increase in your take home pay because of the lower premiums. By switching to one of the CDHPs, you will also have a lower annual maximum personal cost for health care.

Maximum personal costs calculations

We want to encourage everyone to continue to strive to be better, more informed consumers of health care services. That includes making healthier choices. Our lifestyle choices have the greatest correlation to our overall health. The choices we make to eat better, increase physical activity and promote individual wellness have proven to reduce individual healthcare costs. The state plans to add new tools and programs next year to help you be a better consumer and live a healthier life. Watch for more information on this in early 2012.

In addition, please explore the savings opportunities of a CDHP. Since 2006, when

the state initiated CDHPs with the health savings account (HSA), the state has deposited \$117 million into employee accounts. Many employees have also wisely chosen to invest pretax dollars into these accounts. As of June 1, 2011, state employees had a healthy balance of \$49 million in their HSAs. We encourage you to investigate this opportunity during 2012 open enrollment to maximize both the state's contribution, as well as your own, to your healthcare savings.

Single coverage	CDHP 1	CDHP 2	Trad PPO
Premium	\$147.42	\$793.26	\$3,283.02
Maximum out-of-pocket	\$4,000.00	\$3,000.00	\$2,500.00
State's HSA contribution	(\$1,123.20)	(\$673.92)	(0)
Total maximum personal cost	\$3,024.22	\$3,119.34	\$5,783.02
Family coverage	CDHP 1	CDHP 2	Trad PPO
Premium	\$411.32	\$2,233.40	\$9,136.40
Maximum out-of-pocket	\$8,000.00	\$6,000.00	\$5,000.00
State's HSA contribution	(\$2,249.52)	(\$1,347.84)	(0)
Total maximum personal cost	\$6,161.80	\$6,885.56	\$14,136.40

Highlights of the 2012 benefits include:

- Preventive services will continue to be covered in full under all three plans.
- Co-insurance for Trad PPO will be 30% for in-network services. Be sure to carefully review the plan summary. The deductible must be met before the co-insurance applies.
- Non-tobacco use incentive increases from \$10 per pay period to \$25 per pay period.
- For CDHP participants with an HSA, the state will deposit 45% (rather than 50%) of the CDHP deductible into HSAs over the course of 2012. Employees can decide to fund this difference themselves with pretax dollars. Once again, the state will front load the accounts by depositing one-half of its contribution into each open HSA on the first pay of 2012. The remaining contributions by the state will be divided into equal payments and spread out over the year. Total contributions by the state will be:
 - HSA 1 -- \$1,123.20 (single); \$2,249.52 (family)
 - HSA 2 -- \$673.92 (single); \$1,347.84 (family)
- Vision coverage and premiums will remain the same.
- Dental coverage will remain the same; however, the biweekly rate for dental coverage will increase to \$1.20 for single coverage and \$3.16 for family.

A guide to a successful Open Enrollment

Open Enrollment checklist



- Educate yourself about changes occurring January 1, 2012.
- Access your PeopleSoft account.
- Review your Open Enrollment record and carefully read the information.
- Confirm or update your personal information including your home and/or mailing address and phone number.
- Review your eligible dependents and beneficiaries. You will need to enroll all eligible dependents in each plan.
- Check your current election or make new elections. It is important that you review the dependents enrolled on each of your plans.
- If you have a Health Savings Account or a Flexible Spending Account, you will need to re-elect and re-state your annual contribution amount.
- Accept or decline the Non-Tobacco Use Agreement for 2012.
- Be sure to print an Election Summary after you have submitted your elections.

Have questions? Need more help?

For 2012 plan summaries, rates, PeopleSoft instructions and other Open Enrollment information, please log on to www.in.gov/spd/openenrollment.

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.

232-1167 (within Indianapolis)
Toll free 1-877-248-0007 (outside the 317 area code).
SPDBenefits@spd.in.gov

Help sessions will be provided in Training Room 31, in the Indiana Government Center South, throughout Open Enrollment for those needing assistance with entering elections and navigating through PeopleSoft. Hours will be (all are Indianapolis, Eastern Standard Time):

- Week of October 31 – November 4: 8am – 3pm
- Week of November 7 – November 11: 8am – 4pm
- Week of November 14 – November 18: 8am – 5pm
- Monday, November 21: 8am – noon

Education sessions

Information sessions

We hope that you have taken time to log onto the 2012 Open Enrollment website (www.in.gov/spd/openenrollment) and get better acquainted with options for your 2012 benefits.

If you still have questions, we have a few resources outside the Open Enrollment website to help get you the answers you need. We have scheduled town hall informational meetings and webinars (a web-based seminar you access through a computer). Of course, you can always contact the Benefits Division with your questions as well.

Both the town hall meetings and the webinars allow those attending to ask questions. Sessions are expected to last about one hour.

View the updated meeting schedule at www.in.gov/spd/2710.htm



Webinars

To join a webinar session, visit www.webinar.in.gov/spdopenenrollment

Log-in as a guest, with your first and last name. If you are joining as a group, please list your agency or division. Please try to log-into the meeting at least five minutes before the start of the meeting. You will still be allowed to join after it begins; however, we encourage you to join ahead of time so you will not miss any information. Make sure your computer speakers are turned on and at a comfortable level to hear the presenter. You will be able to ask questions through the “chat” feature, which will be shown on the left side of the screen.

Webinar Schedule

Monday October 24:

8:30 to 9:30 am
1:30 to 2:30 pm

Tuesday October 25:

1 to 2 pm

Wednesday October 26:

8:30 to 9:30 am
1:30 to 2:30 pm

Thursday October 27:

8:30 to 9:30 am
1:30 to 2:30 pm

Friday October 28:

9 to 10 am

Monday October 31:

8:30 to 9:30 am

Tuesday November 1:

1:30 to 2:30 pm



Your benefits in 2012

Effective dates

Health, dental, vision, Health Savings Accounts and Flexible Spending Accounts changes/enrollments will be effective Jan. 1, 2012. Life insurance changes/enrollments that do not require Evidence of Insurability with approval from AUL will be effective Jan. 8, 2012, for payroll A and Jan. 1, 2012, for payroll B.

Deductions for health, dental and vision will begin:

Payroll A: Dec. 21, 2011 (7 days at old plans & rates; 7 days for new plans & rates)

Payroll B: Dec. 28, 2011 (full 2012 rates)

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

Payroll A: Jan. 4, 2012

Payroll B: Jan. 11, 2012

What's new?

There are new rates for all medical plans, the dental plan and modified HSA contributions, but you also need to review each plan. The Traditional PPO out-of-pocket maximum will change as well as the co-insurance amounts. Be sure to compare all three health plans offered. There are a number of resources available to help you estimate your 2012 expenses, compare plans and become a more informed consumer. And last, but not least, the Non-Tobacco Use Incentive is increasing to \$25 biweekly. You can earn a \$650 reduction in premiums in 2012 if you pledge to abstain from tobacco use.

Non-tobacco use incentive

The state is offering a **\$25 reduction in health plan premiums each pay period** for those state employees who agree to not use tobacco during 2012. This is an increase over previous years. In 2011, the state offered a \$10 reduction per pay.

State employees will need to accept the Non-Tobacco Use Agreement, pledging to not use any tobacco products during 2012 and agree to undergo nicotine testing. This applies to employees who have never used tobacco products, to 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, 2012. The use of tobacco includes **all forms**, whether smoking, chewing or any other methods of use.



**Non-tobacco
use incentive**

Keep in mind, by accepting the agreement you are also agreeing to be subject to testing for nicotine at anytime during the year. The Non-Tobacco Use Agreement does not carry over from year to year, but must be completed during Open Enrollment.

The 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 2012. The reduction in your group health insurance biweekly 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 Incentive during Open Enrollment and later use tobacco, your employment will be terminated. The only exception to the job loss penalty is if you rescind 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.

Health plans for 2012

Summary

The state is continuing to offer three statewide plans: Consumer Driven Health Plan 1 (CDHP 1), Consumer Driven Health Plan 2 (CDHP 2) and Traditional PPO. All three available plans are in the Blue Access PPO network with Anthem and have the same prescription drug plan through Medco. Each plan has differences in premium costs, deductibles and out-of-pocket maximums.

Here are the differences at a glance:

	CDHP 1	CDHP 2	Traditional PPO
Deductible	\$2,500 single \$5,000 family	\$1,500 single \$3,000 family	\$750/\$1,500 single \$1,500/\$3,000 family
Co-insurance/non-network	20%/40%	20%/40%	30%/50%
Preventive services	Covered in full	Covered in full	Covered in full
Out-of-pocket maximum	\$4,000 single \$8,000 family	\$3,000 single \$6,000 family	\$2,500/\$5,000 single \$5,000/\$10,000 family

For the new plan year, the Traditional PPO plan has been redesigned. While the deductible for the plan will remain the same, the co-insurance will now be 30% for most in-network services after the deductible is met and before the out-of-pocket maximum is reached. If you are a Traditional PPO participant, be sure to review all of the changes.

All three plans offer 100 % coverage on preventive services such as: annual physicals, well baby visits, mammograms, prostate exams, routine vaccines and annual pap smears. Premiums, co-insurance, out-of-pocket maximum expenditures and contributions to Health Savings Accounts (HSAs) are all part of the equation to make the best decision with your health care dollars.

State of Indiana 2012 Rates

Plan	Coverage	Biweekly Employee Rate	Biweekly Employer Rate	Biweekly Total Rate	Early Retirees (Monthly)	COBRA (Monthly)	Annual Employee Rate	Annual Employer Rate	Annual Employer HSA Contribution	Total Annual Employer Contribution	Annual Total Rate
CDHP 1	Single	\$30.67	\$153.35	\$184.02	\$398.71	\$406.68	\$797.42	\$3,987.10	\$1,123.20	\$5,110.30	\$5,907.72
	Family	\$40.82	\$482.92	\$523.74	\$1,134.77	\$1,157.47	\$1,061.32	\$12,555.92	\$2,249.52	\$14,805.44	\$15,866.76
CDHP 1 W/ Non-Tobacco Use Incentive	Single	\$5.67	\$153.35	\$159.02	\$344.54	\$351.43	\$147.42	\$3,987.10	\$1,123.20	\$5,110.30	\$5,257.72
	Family	\$15.82	\$482.92	\$498.74	\$1,080.60	\$1,102.21	\$411.32	\$12,555.92	\$2,249.52	\$14,805.44	\$15,216.76
CDHP 2	Single	\$55.51	\$170.63	\$226.14	\$489.97	\$499.77	\$1,443.26	\$4,436.38	\$673.92	\$5,110.30	\$6,553.56
	Family	\$110.90	\$517.60	\$628.50	\$1,361.75	\$1,388.99	\$2,883.40	\$13,457.60	\$1,347.84	\$14,805.44	\$17,688.84
CDHP 2 W/ Non-Tobacco Use Incentive	Single	\$30.51	\$170.63	\$201.14	\$435.80	\$444.52	\$793.26	\$4,436.38	\$673.92	\$5,110.30	\$5,903.56
	Family	\$85.90	\$517.60	\$603.50	\$1,307.58	\$1,333.73	\$2,233.40	\$13,457.60	\$1,347.84	\$14,805.44	\$17,038.84
Traditional PPO	Single	\$151.27	\$196.55	\$347.82	\$753.61	\$768.68	\$3,933.02	\$5,110.30	\$0.00	\$5,110.30	\$9,043.32
	Family	\$376.40	\$569.44	\$945.84	\$2,049.32	\$2,090.31	\$9,786.40	\$14,805.44	\$0.00	\$14,805.44	\$24,591.84
Traditional PPO W/ Non-Tobacco Use Incentive	Single	\$126.27	\$196.55	\$322.82	\$699.44	\$713.43	\$3,283.02	\$5,110.30	\$0.00	\$5,110.30	\$8,393.32
	Family	\$351.40	\$569.44	\$920.84	\$1,995.15	\$2,035.05	\$9,136.40	\$14,805.44	\$0.00	\$14,805.44	\$23,941.84
Dental	Single	\$1.20	\$10.02	\$11.22	\$24.31	\$24.80	\$31.20	\$260.52	\$0.00	\$260.52	\$291.72
	Family	\$3.16	\$26.36	\$29.52	\$63.96	\$65.24	\$82.16	\$685.36	\$0.00	\$685.36	\$767.52
Vision	Single	\$0.17	\$1.47	\$1.64	\$3.55	\$3.62	\$4.42	\$38.22	\$0.00	\$38.22	\$42.64
	Family	\$2.52	\$1.64	\$4.16	\$9.01	\$9.19	\$65.52	\$42.64	\$0.00	\$42.64	\$108.16

Flexible Spending Accounts										
Medical, Limited Purpose Medical (HSA Holders) and/or Dependent Care Admin Fee	\$2.00	\$0.00	\$2.00	\$4.33	\$4.33	\$52.00	\$0.00	\$0.00	\$0.00	\$52.00

HSA Accounts	Coverage	Initial Contribution *	Biweekly Contribution	Monthly Contribution	Maximum Annual ER Contribution
HSA 1	Single	\$561.60	\$21.60	\$46.80	\$1,123.20
	Family	\$1,124.76	\$43.26	\$93.73	\$2,249.52
HSA 2	Single	\$336.96	\$12.96	\$28.08	\$673.92
	Family	\$673.92	\$25.92	\$56.16	\$1,347.84

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

Employees participating in CDHPs are reminded that they must open an HSA in order to receive the state's HSA contribution or the bank will charge a set-up fee.

Health plans for 2012

CDHP 1

State of Indiana - Consumer-Driven Health Plan 1 Blue AccessSM for Health Savings Accounts Summary of Benefits, Effective January 1, 2012

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.

Covered Benefits	Network	Non-Network
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage. (Deductibles are combined network and non-network)		Single: \$2,500 Family: \$5,000
Out-of-Pocket Limit (OOP) (Single/Family) 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		Single: \$4,000 Family: \$8,000
Physician Home and Office Services Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including office surgeries and allergy serum: <ul style="list-style-type: none"> allergy injections (PCP and SCP) and allergy testing non-routine mammograms diabetic education (regardless of outpatient setting) MRAs, MRIs, PETS, C-scans, nuclear cardiology imaging studies and non-maternity related ultrasounds 	20%	40%
Preventive Care Services Services include but are not limited to: Annual physical exams, pelvic exams, pap testing, PSA tests, immunizations, annual diabetic eye exam, routine vision and hearing exams <ul style="list-style-type: none"> Physician home and office visits (PCP/SCP) Other outpatient services @ hospital/alternative care facility Routine mammograms Screening colorectal cancer exam/laboratory testing 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	No deductible/coinsurance	40% (not subject to deductible)
Emergency and Urgent Care <ul style="list-style-type: none"> Emergency Room services @ hospital (facility/other covered services) Urgent Care Center services 	20%	20%
Maternity Services	20%	40%
Inpatient and Outpatient Professional Services Include but are not limited to: <ul style="list-style-type: none"> Medical care visits, intensive medical care, concurrent care, consultations, surgery and administration of general anesthesia and Newborn exams 	20%	40%
Inpatient Facility Services	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> Surgery and administration of general anesthesia 	20%	40%

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. An independent licensee of the Blue Cross and Blue Shield Association.
 ©Registered marks Blue Cross and Blue Shield Association.

Health plans for 2012

CDHP 1

Covered Benefits	Network	Non-Network
Other Outpatient Services (including but not limited to): <ul style="list-style-type: none"> Non-surgical outpatient services for example: MRIs, C-scans, chemotherapy, ultrasounds and other diagnostic outpatient services. Home care services (network/non-network combined) Unlimited visits (includes IV therapy) (\$5,000 Private Duty Nursing lifetime max applies) (No RN/LPN unless billed through a home health care agency) Durable medical equipment and orthotics (network/non-network combined) Unlimited benefit maximum (including medical supplies) Prosthetic devices unlimited benefit maximum for prosthetics received on an outpatient basis. (Surgical prosthetics do not apply) Physical medicine therapy day rehabilitation programs 	20%	40%
<ul style="list-style-type: none"> Hospice care Ambulance services 	20%	20%
Outpatient Therapy Services (Combined network and non-network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other outpatient services @ hospital/alternative care facility <ul style="list-style-type: none"> Physical therapy: 25 visits Occupational therapy: 25 visits Manipulation therapy: 12 visits Speech therapy: 25 visits 	20%	40%
Behavioral Health Services: Mental Health and Substance Abuse¹ <ul style="list-style-type: none"> Inpatient facility services (Residential MH/SA covered as inpatient) Physician home and office visits (PCP/SCP) Other outpatient services @ hospital/alternative care facility 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 Transplants² <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage 	20%	40%
Prescription Drug Coverage – THIS COVERAGE IS ADMINISTERED BY MEDCO³ Below benefits apply after medical deductible has been met; prescription expenses accumulate to the OOP maximum		
	Retail Rx (Up to a 30-day supply)	Mail Order Rx (Up to a 90-day supply)
Generic	\$10 co-pay	\$20 co-pay
Formulary	20% - minimum \$30, maximum \$50	20% - minimum \$60, maximum \$100
Brand Non-Formulary	40% - minimum \$50, maximum \$70	40% - minimum \$100, maximum \$140
Specialty	40% - minimum \$75, maximum \$150 (30-day supply only)	

Notes:

- Non-network human organ and tissue transplants are excluded from the out-of-pocket limits.
- Dependent age: to the child's 26th birthday
- 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.

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 MEDCO. ANY QUESTIONS RELATED TO RX NEED TO BE DIRECTED TO (877)841-5241

Precertification:

- Members are encouraged to always 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 2012

CDHP 2

State of Indiana - Consumer-Driven Health Plan 2 Blue AccessSM for Health Savings Accounts Summary of Benefits, Effective January 1, 2012

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.

Covered Benefits	Network	Non-Network
Deductible <i>Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage. (Deductibles are combined network and non-network)</i>		Single: \$1,500 Family: \$3,000
Out-of-Pocket Limit (OOP) (Single/Family) <i>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</i>		Single: \$3,000 Family: \$6,000
Physician Home and Office Services Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including office surgeries and allergy serum: <ul style="list-style-type: none"> allergy injections (PCP and SCP) and allergy testing non-routine mammograms MRAs, MRIs, PETS, C-scans, nuclear cardiology imaging studies and non-maternity related ultrasounds 	20%	40%
Preventive Care Services Services include but are not limited to: Annual physical exams, pelvic exams, pap testing, PSA tests, immunizations, annual diabetic eye exam, routine vision and hearing exams <ul style="list-style-type: none"> Physician home and office visits (PCP/SCP) Other outpatient services @ hospital/alternative care facility Routine mammograms Screening colorectal cancer exam/laboratory testing 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	No deductible/coinsurance	40% (not subject to deductible)
Emergency and Urgent Care <ul style="list-style-type: none"> Emergency Room services @ hospital (facility/other covered services) Urgent Care Center services 	20%	20%
Maternity Services	20%	40%
Inpatient and Outpatient Professional Services Include but are not limited to: <ul style="list-style-type: none"> Medical care visits, intensive medical care, concurrent care, consultations, surgery and administration of general anesthesia and Newborn exams 	20%	40%
Inpatient Facility Services	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> Surgery and administration of general anesthesia 	20%	40%

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. An independent licensee of the Blue Cross and Blue Shield Association.
 ©Registered marks Blue Cross and Blue Shield Association.

Health plans for 2012

CDHP 2

Covered Benefits	Network	Non-Network
Other Outpatient Services <i>(including but not limited to):</i> <ul style="list-style-type: none"> Non-surgical outpatient services for example: MRIs, C-scans, chemotherapy, ultrasounds and other diagnostic outpatient services. Home care services (network/non-network combined) Unlimited visits (includes IV therapy) (\$5,000 Private Duty Nursing lifetime max applies) (No RN/LPN unless billed through a home health care agency) Durable medical equipment and orthotics (network/non-network combined) Unlimited benefit maximum (including medical supplies) Prosthetic devices unlimited benefit maximum for prosthetics received on an outpatient basis. (Surgical prosthetics do not apply) Physical medicine therapy day rehabilitation programs 	20%	40%
<ul style="list-style-type: none"> Hospice care Ambulance services 	20%	20%
Outpatient Therapy Services (Combined network and non-network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other outpatient services @ hospital/alternative care facility <ul style="list-style-type: none"> Physical therapy: 25 visits Occupational therapy: 25 visits Manipulation therapy: 12 visits Speech therapy: 25 visits 	20%	40%
Behavioral Health Services: Mental Health and Substance Abuse¹ <ul style="list-style-type: none"> Inpatient facility services (Residential MH/SA covered as inpatient) Physician home and office visits (PCP/SCP) Other outpatient services @ hospital/alternative care facility 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 Transplants² <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage 	20%	40%
Prescription Drug Coverage – THIS COVERAGE IS ADMINISTERED BY MEDCO³ Below benefits apply after medical deductible has been met; prescription expenses accumulate to the OOP maximum		
	Retail Rx (Up to a 30-day supply)	Mail Order Rx (Up to a 90-day supply)
Generic	\$10 co-pay	\$20 co-pay
Formulary	20% - minimum \$30, maximum \$50	20% - minimum \$60, maximum \$100
Brand Non-Formulary	40% - minimum \$50, maximum \$70	40% - minimum \$100, maximum \$140
Specialty	40% - minimum \$75, maximum \$150 (30 day supply only)	

Notes:

- Non-network human organ and tissue transplants are excluded from the out-of-pocket limits.
- Dependent age: to the child's 26th birthday
- 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.

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 MEDCO. ANY QUESTIONS RELATED TO RX NEED TO BE DIRECTED TO (877)841-5241

Precertification:

- Members are encouraged to always 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 2012

Traditional PPO

State of Indiana - Traditional PPO

Blue AccessSM (PPO)

Summary of Benefits, Effective January 1, 2012

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.

Covered Benefits	Network	Non-Network
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage.	\$750/\$1,500	\$1,500/\$3,000
Out-of-Pocket Limit (OOP) (Single/Family) Family coverage requires the family OOP to be met before 100% coverage applies. The single OOP does not apply to family coverage.	\$2,500/\$5,000	\$5,000/\$10,000
Physician Home and Office Services Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including office surgeries and allergy serum: <ul style="list-style-type: none"> allergy injections (PCP and SCP) and allergy testing non-routine mammograms diabetic education (regardless of outpatient setting) MRAs, MRIs, PETS, C-scans, nuclear cardiology imaging studies and non-maternity related ultrasounds 	30%	50%
Preventive Care Services Services include but are not limited to: Annual physical exams, pelvic exams, pap testing, PSA tests, immunizations, annual diabetic eye exam, routine vision and hearing exams <ul style="list-style-type: none"> Physician home and office visits (PCP/SCP) Other outpatient services @ hospital/alternative care facility Routine mammograms Screening colorectal cancer exam/laboratory testing 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	No deductible/coinsurance	50% (not subject to deductible)
Emergency and Urgent Care <ul style="list-style-type: none"> Emergency Room services @ hospital (facility/other covered services) Urgent Care Center services 	30%	30%
Maternity Services	30%	50%
Inpatient and Outpatient Professional Services Include but are not limited to: <ul style="list-style-type: none"> Medical care visits, intensive medical care, concurrent care, consultations, surgery and administration of general anesthesia and Newborn exams 	30%	50%
Inpatient Facility Services	30%	50%
Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> Surgery and administration of general anesthesia 	30%	50%

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. An independent licensee of the Blue Cross and Blue Shield Association.
 ©Registered marks Blue Cross and Blue Shield Association.

Health plans for 2012

Traditional PPO

Covered Benefits	Network	Non-Network
Other Outpatient Services (including but not limited to): <ul style="list-style-type: none"> Non-surgical outpatient services for example: MRIs, C-scans, chemotherapy, ultrasounds and other diagnostic outpatient services. Home care services (network/non-network combined) Unlimited visits (includes IV therapy) (\$5,000 Private Duty Nursing lifetime max applies) (No RN/LPN unless billed through a home health care agency) Durable medical equipment and orthotics (network/non-network combined) Unlimited benefit maximum (including medical supplies) Prosthetic devices unlimited benefit maximum for prosthetics received on an outpatient basis. (Surgical prosthetics do not apply) Physical medicine therapy day rehabilitation programs 	30%	50%
<ul style="list-style-type: none"> Hospice care Ambulance services 	30%	30%
Outpatient Therapy Services (Combined network and non-network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other outpatient services @ hospital/alternative care facility <ul style="list-style-type: none"> Physical therapy: 25 visits Occupational therapy: 25 visits Manipulation therapy: 12 visits Speech therapy: 25 visits 	30%	50%
Behavioral Health Services: Mental Health and Substance Abuse¹ <ul style="list-style-type: none"> Inpatient facility services (Residential MH/SA covered as inpatient) Physician home and office visits (PCP/SCP) Other outpatient services @ hospital/alternative care facility Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained, benefits will not be allowed.	30%	50%
Human Organ and Tissue Transplants² <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage 	30%	50%
Prescription Drug Coverage – THIS COVERAGE IS ADMINISTERED BY MEDCO³ Below benefits apply after medical deductible has been met; prescription expenses accumulate to the OOP maximum		
	Retail Rx (Up to a 30-day supply)	Mail Order Rx (Up to a 90-day supply)
Generic	\$10 co-pay	\$20 co-pay
Formulary	20% - minimum \$30, maximum \$50	20% - minimum \$60, maximum \$100
Brand Non-Formulary	40% - minimum \$50, maximum \$70	40% - minimum \$100, maximum \$140
Specialty	40% - minimum \$75, maximum \$150 (30 day supply only)	

Notes:

- Non-network human organ and tissue transplants are excluded from the out-of-pocket limits.
- Dependent age: to the child's 26th birthday
- 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.

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 MEDCO. ANY QUESTIONS RELATED TO RX NEED TO BE DIRECTED TO (877)841-5241

Precertification:

- Members are encouraged to always 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 2012

Health Savings Accounts

There are a number of ways to control our health care expenses. In addition to making better lifestyle choices, consider a consumer-driven health plan (CDHP) and its companion, the health savings account (HSA). In order to have a HSA, you must have a CDHP.

A HSA, which is a special, tax-qualified consumer bank account, allows you to set aside money to pay for qualified health-related costs. You can direct money to the account and, a bonus to state employees, if you are covered by one of the state's CDHP/HSAs, the state will prefund the account and make biweekly payments throughout the calendar year. Regardless who makes deposits into the account, all funds in your HSA belong to you, the employee. Even if you leave state employment. The money goes with you and it's tax-free. Unlike the flexible spending account, money in a HSA accumulates. There is no use-it-or-lose-it consequence. The money can roll over year after year.

HSA Account	Coverage	Initial Contribution	Bi-Weekly Contribution	Monthly Contribution	Maximum Annual ER Contribution *
HSA 1 w/ CDHP 1	Single	\$561.60	\$21.60	\$46.80	\$1,123.20
	Family	\$1,124.76	\$43.26	\$93.73	\$2,249.52
HSA 2 w/ CDHP 2	Single	\$336.96	\$12.96	\$28.08	\$673.92
	Family	\$673.92	\$25.92	\$56.16	\$1,347.84

*ER = employer contribution

With a HSA, you can decide how much to contribute to the account, whether to pay for current medical expenses from it or save the money for future use. Once the balance reaches \$1,000, it begins to earn interest.

For 2012, the maximum that can be contributed to a HSA is \$3,100 for single coverage and \$6,250 for family coverage. This includes contributions made by the employee and the state. For individuals 55 years of age and older, an additional \$1,000 can be contributed to the account.

Tower Bank provides the HSA program for the state of Indiana. In order to have the state deposit money into an employee's HSA, the employee must first open their HSA with Tower Bank after completing the Open Enrollment process.

HSA Basics

A Health Savings Account 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, but you may elect to designate an authorized signer that may also withdrawal 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;
- 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 benefits for anything other than preventative services in the past three months.

Contributions to your HSA

The annual maximum allowable contributions to an HSA, as established by the IRS for 2012 are:

- Individual: \$3,100
- Family: \$6,250

Individuals 55 and older can make an additional catch-up contribution of \$1,000 in 2012. 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 Rollover (contact us for assistance)

Advantages of a Health Savings Account

Portability: Take 100% of the deposited funds with you when you retire or change employers. You are the account owner.

Flexibility: Choose whether to spend on current medical expenses or to save for the future. 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: HSA qualified insurance plans are usually less expensive than traditional insurance plans.

Distributions from your HSA

- You, or your authorized signer, can make withdrawals for qualified expenses.
- Withdrawals or distributions from your HSA can be made by check, debit card, ATM, or by request (in person or via telephone).
- Distributions for qualified medical expenses are tax free (refer to next page for examples).
- 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 medical insurance plan (CDHP).
- You are responsible for keeping receipts for all distributions from your HSA. The bank does not monitor how the funds in your account are spent.

Qualified Medical Expenses

- Expenses incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease are eligible expenses; such as prescription drugs, and costs incurred by you or your spouse and your tax dependents for doctor visits, lab tests, hospital stays, or clinic visits. These may, or may not, apply to your insurance deductible depending on the coverage provided by your medical plan.
- Vision expenses such as glasses, contact lenses and supplies, eye exams, and vision correction surgery.
- Dental care expenses such as orthodontia.
- Medical supplies such as Band-Aids, contact solution, crutches, and test strips.
- Insurance premiums only under the following circumstances: while receiving federal or state unemployment benefits, paying COBRA premiums, premiums paid for qualified long-term care insurance, and Medicare premiums after age 65.

Expenses Generally NOT Eligible

- Insurance premiums are not eligible expenses (exceptions listed above).
- Costs associated with non-medically necessary treatments such as 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.
- As of January 1, 2011, over-the-counter medications are not eligible unless you obtain a prescription from a doctor. The prescription is not required at the time of purchase; however, please retain it for your records in the event it is needed by the IRS.

What If...

It's early in the year and you're faced with a medical emergency. You have a large hospital bill but do not have the full amount in your HSA to pay your portion.

1. Ask to set up a payment plan. As funds are deposited into your HSA (through payroll withholding, employer contributions, or other) you can make payments to the provider using your HSA debit card or checks.
2. Pay the bill with another personal checking account, savings account, or credit card and then repay yourself as the funds accumulate in your HSA. Be sure to negotiate a discounted price from your provider for paying in-full upfront. Most providers will agree to a 10%-30% discount.

You receive a bill in the mail from your doctor, hospital, lab, or urgent care and need to submit a payment. You have the funds available in your HSA.

1. You can write your HSA debit card number on the provider invoice and have the payment debited from your account.
2. You can write a check from your HSA and mail in the payment. (Be sure your insurance company has already processed the bill and that you're only paying your portion of the negotiated rate.)

You fill a prescription at the pharmacy and need to pay for your medication.

1. You can pay using your HSA debit card.
2. You can write a check from your HSA, payable to the pharmacy.

You are at the pharmacy paying for your medication and realize you don't have your HSA debit card or checks with you, or you don't have sufficient funds in your account to cover the purchase.

1. You can pay for the purchase with cash, personal credit card, debit card, or check and later repay yourself by writing yourself a check from your HSA or making an ATM withdrawal.

You're shopping at your local convenience store and purchase groceries and a prescription at the same time. How should you handle the register transaction?

1. You can ring up your other purchases separately from your medical purchase and use your HSA debit card or checks for the prescription only.
2. You can ring everything up in one transaction, pay with cash or another account, and then repay yourself for the medical portion of the purchase later from your HSA funds.

You are required to pay for treatment at the time of service. Later, you receive reimbursement from the provider.

1. Cash the check and pay for other eligible medical expenses.
2. Mail the check to Tower Bank for deposit into your HSA, indicating that it's a reimbursement.

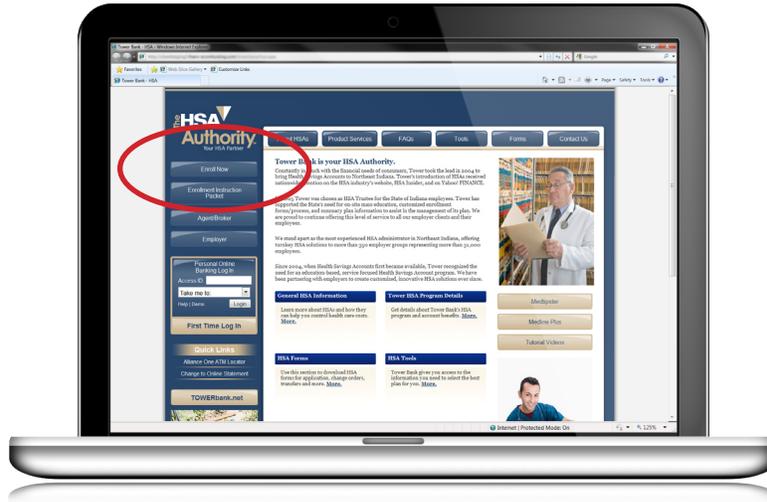
Open Your HSA Online

You will need the following information when you begin:

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

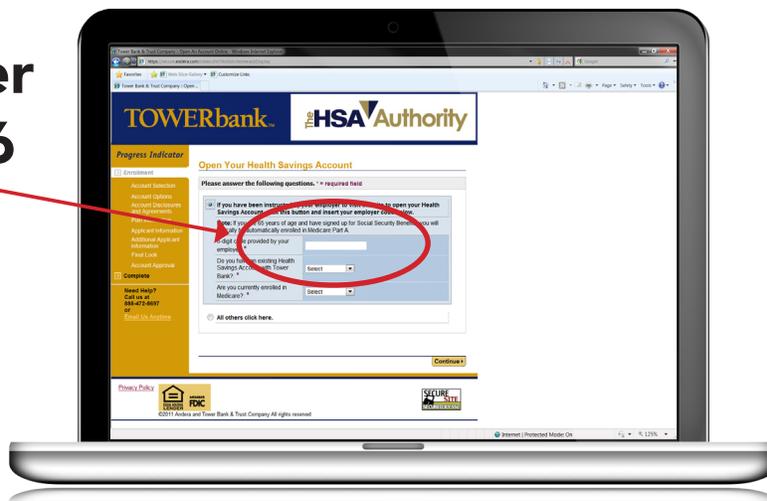
Complete the following steps to open your account:

1. Go to theHSAauthority.com and click on the blue "Enroll Now" button. This will take you to the enrollment program.



2. In the enrollment program, select the "If you have been instructed by your employer..." option. The prompt to enter your 6-digit employer code will appear. Enter the code that was provided by your employer.

**Your Employer
Code: 100366**



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 or checks, they will be mailed separately and will arrive following the welcome letter.

To Access Your Account

The welcome letter you'll receive contains your new Health Savings Account number along with instructions for accessing Tower Bank's online banking site and telephone banking system. If you would like assistance using these services, please call Customer Care toll-free at 1.888.472.8697, option 1.



Product Features

Enrollment Fee

- Online Enrollment: Free
- Paper Enrollment: \$14.99

Minimum Opening Balance

- None

Annual Fee

- None

Service Charge

- No monthly service charge

Statement Options

- Online or paper statements available

Interest Rates

- Interest rates may vary based on account balance and statement type (online or paper); rates are subject to change; refer to our website for information or call our Customer Care Center at 1.888.472.8697, option 1

Annual IRS Reporting and Updates

- 5498-SA (contributions); 1099-SA (distributions); and adjustments for prior year contributions

24/7 Automated Telephone Banking

- Toll-free number: 1.888.743.0737

Deposit Processing

- Automatic deposit; mail-in service; or in-person at any Tower Bank location

Online Banking

- View statement, account activity, balance, and front and back of paid checks - all at no charge

Debit Card

- Up to two free cards (account owner and authorized signer)

ATM Access

- Free ATM withdrawals at any Tower Bank ATM
- ATM withdrawals at non-Tower ATMs will have fees applied; refer to the bank fee schedule for more information

Check Fees

- No per-check fee
- See website for current printing cost on 50 checks per order

Certificate of Deposit Options

- Available; call for current rates and terms; FDIC insured

Brokerage Investment Options

- Available; Call for more information; not FDIC insured

Miscellaneous Services

- Manual Account Opening: \$20.00
- HSA Excess Contribution Distribution: \$20.00
- Account Closing/Rollover/Transfer: \$20.00

Standard Bank Services (Overdraft, stop pay, etc.)

- Refer to the bank fee schedule on our website or call our Customer Care Center

Contact Info

- The HSA Authority
P.O. Box 11454
Fort Wayne, IN 46858
- 1.888.472.8697, option 1
Monday - Friday
8:00am - 6:00pm EST
- info@theHSAauthority.com

*Related service fees are subject to change. Please refer to our website for current information. More details, and a list of eligible expenses, can be found at theHSAauthority.com, or refer to IRS Publication 502 titled "Medical and Dental Expenses" (Catalog No. 15002Q), or Pub. 969 titled "HSA and Other Tax-Favored Health Plans" (Catalog No. 242165). Publications can be ordered from the IRS by calling 1-800-TAX-FORM, or online at www.irs.gov. Tower Bank does not sell insurance, or give advice on insurance plan coverage or taxes. Consult your tax advisor or insurance professional for details.



Additional benefits

Medco prescription coverage

Medco Health Solutions, Inc. (Medco) administers the state's prescription drug benefit. To learn more about the state's retail and mail-order prescription drug programs through Medco and some of the cost- and time-saving features that provide value to our employees:



- Visit www.medco.com
- Call 1-877-841-5241

Note: The ID card that you receive from Anthem includes information about Medco and your identification number that the pharmacy will use.

State of Indiana Rx Benefit Comparison Summary of Benefits for 2012

Deductibles and out-of-pocket maximums:

	CDHP 1		CDHP 2		Traditional PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible						
Single	\$2,500		\$1,500		\$ 750	\$1,500
Family	\$5,000		\$3,000		\$1,500	\$3,000
Out-of-pocket maximum						
Single	\$4,000		\$3,000		\$2,500	\$5,000
Family	\$8,000		\$6,000		\$5,000	\$10,000

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

Prescription drugs	Retail (30 days)	Mail order (90 days)
Generic	\$10 copay	\$20 copay
Brand, Formulary	20% Min \$30, max \$50	20% Min \$60, max \$100
Brand, Non-formulary	40% Min \$50, max \$70	40% Min \$100, max \$140
Specialty	40% min \$75, max \$150 (30 day supply)	

Additional benefits

Dental coverage

Delta Dental will continue to be the carrier and coverage will remain unchanged for 2012. As with the state's health care plans, the dental plan provides 100% diagnostic and preventive coverage, provided an in-network dentist is used.

Also covered 100% is emergency palliative treatment (used to temporarily relieve pain), x-rays and sealants (to prevent decay of pits and fissures of permanent back teeth). There are limits to the coverage of sealants, however, so please check with Delta Dental before agreeing to the treatment.

The plan covers 80% of the cost for oral surgery, fillings, the repair of diseased, damaged or injured teeth, relines and repairs to bridges and dentures and single crowns, provided an in-network dentist is used.

More information is available about dental coverage by logging on here: www.in.gov/spd/2702.htm.

Contact Delta Dental

- Call Customer Service department at (800) 524-0149
- Access website: www.deltadentalin.com

About Delta Dental

Having Delta Dental coverage makes it easy for employees to get dental care almost anywhere in the world! You can now receive expert dental care when you're outside of the United States through Delta Dental Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check the website or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum payment - \$1,000 per person total per benefit year on Class I, Class II and Class III benefits. Delta Dental's payment for Class IV benefits will not exceed a lifetime maximum of \$1,125 per eligible person.

Deductible - \$50 deductible per person total per benefit year limited to a maximum deductible of \$150 per family per benefit year on Class II and Class III benefits. The deductible does not apply to Class I or Class IV benefits.

Any expenses incurred by an eligible person for covered services during the last three months of a benefit year that are applied to the deductible for that benefit year will also be applied to the deductible for the following benefit year.

Waiting period - Employees who are eligible for dental benefits can be covered on the fourth day following the first payroll deduction and those on the monthly billing will be eligible the first of the month following the first contribution.

Eligible people - All eligible individuals who meet the guidelines as indicated by the state of Indiana, all full-time active and elected or appointed officers and officials of the state of Indiana, benefit-eligible early retirees, participating Local Units of Government employees and all individuals who are eligible for and elect continuation of coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, if applicable.

Also eligible are your legal spouse and your children to their 26th birthday.

Additional benefits

Dental coverage



**Delta Dental PPO Point-of-Service
Summary of Dental Plan Benefits
STATE OF INDIANA – Group #9840
LOCAL UNITS OF GOVERNMENT – Group #9842**

This Summary of Dental Plan Benefits and Dental Care Certificate will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. In the event that you seek treatment from a dentist that does not participate in any of Delta Dental's programs, you may be responsible for more than the percentage indicated below.

Control Plan - Delta Dental of Indiana
Benefit Year - January 1 through December 31

Covered Services -	PPO Dentist		Premier Dentist		Nonparticipating Dentist	
	Plan Pays	You Pay	Plan Pays	You Pay	Plan Pays	You Pay
Class I Benefits						
Diagnostic and Preventive Services - Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings and fluoride treatments).	100%	0%	100%	0%	90%	10%
Emergency Palliative Treatment - Used to temporarily relieve pain.	100%	0%	100%	0%	90%	10%
Radiographs - X-rays	100%	0%	100%	0%	90%	10%
Sealants - Used to prevent decay of pits and fissures of permanent back teeth. Limited to first molars to age 9, and second molars to age 14.	100%	0%	100%	0%	90%	10%
Class II Benefits						
Oral Surgery Services - Extractions and dental surgery, including preoperative and postoperative care.	80%	20%	80%	20%	70%	30%
Endodontic Services - Used to treat teeth with diseased or damaged nerves (for example, root canals).	80%	20%	80%	20%	70%	30%
Periodontic Services - Used to treat diseases of the gums and supporting structures of the teeth.	80%	20%	80%	20%	70%	30%
Minor Restorative Services - Used to repair teeth damaged by disease or injury (for example, fillings).	80%	20%	80%	20%	70%	30%
Relines and Repairs - Relines and repairs to bridges and dentures.	80%	20%	80%	20%	70%	30%
Single Crowns & Cores - Used when teeth can't be restored with another filling material.	80%	20%	80%	20%	70%	30%
Class III Benefits						
Prosthetic Services - Used to replace missing natural teeth (for example, bridges and dentures).	60%	40%	60%	40%	50%	50%
Other Major Restorative Services (Inlays & Onlays) - Used when teeth can't be restored with another filling material.	60%	40%	60%	40%	50%	50%
Class IV Benefits						
Orthodontic Services (no age limit) - Used to correct malposed teeth (for example, braces).	60%	40%	60%	40%	50%	50%

Additional benefits

Vision coverage

For the third consecutive year, there are no changes in vision coverage or premiums for 2012. Anthem Blue Vision Select will again provide coverage.

With Anthem Blue View Vision Select, you can take advantage of a large vision care network, including ophthalmologists, optometrists and opticians, as well as discounts. Blue View Vision's select network also includes retail locations, many with evening and weekend hours, such as LensCrafters®, Target Optical®, JCPenney® Optical, Sears OpticalSM and Pearle Vision® stores.

If you decide to use an out-of-network vision provider, Blue View Vision Select will provide you with an allowance toward the services and you pick up the remaining balance. However, in-network benefits and discounts will not apply. You will need to pay in full at the time of service and then file a claim for reimbursement.

Blue View Vision Select will only accept itemized receipts that indicate the services provided and the amount charged for each service. In addition, services must be paid in full to receive benefits. Please review the Blue View Vision Reimbursement Form instructions for more information prior to submission.

Blue View Vision Select provider directory

ProviderFinder

Search By Location | [Lookup By Name](#) | [Provider Finder Help](#)

Find Providers Near a Location

Español

Select a Plan

- » (None Selected)
- Blue Priority (HMO/POS)
- Blue Traditional
- BlueCard PPO
- » Anthem Dental
- Dental Blue
- Dental Blue 100
- Dental Blue 200
- Dental Blue 300
- » Dental Blue 100/200/300
- Dental Complete
- » Dental Prime
- Healthy Indiana Buy In Level 2
- Healthy Indiana Plan And Healthy Indiana Buy In Level 1
- Lumenos plans
- Medicare Select
- Anthem Vision, Anthem Blue Vision
- Blue View Vision
- Blue View Vision Insight
- Blue View Vision Select
- Federal Employee Program - Basic/Standard Option

[Plan Information](#)

HOW TO FIND A PROVIDER

1. Link to the [Provider Directory](#)
2. Select Indiana from the list of states
3. Pick Blue View Vision Select (as shown at left) from the menu under Select a Plan.
4. Use the Provider search and view your results.

Blue View VisionSM Select

STATE OF INDIANA



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. Blue View Vision's Select Network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters®, Target Optical®, JCPenney® Optical, Sears OpticalSM, and Pearle Vision® stores. 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.

LENSCRAFTERS®



Vision Care Services	Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary	\$10 Copay	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 15% off balance over \$105	Up to \$95
Disposable Elective	\$0 Copay; \$105 allowance	Up to \$95
Non-elective	\$0 Copay; Paid in full	Up to \$165
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
Low Vision (subject to prior approval)	\$0 Copay \$1,000 Lifetime Max.	\$0 Copay \$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 disposable and frequent replacement.

**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; Routine Exams or Tests. Routine examinations required by an employer in connection with insured person's employment; Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if insured person does not claim those benefits; Government Treatment. Any services actually given to the insured person by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if insured person is not required to pay for them or they are given to the insured person for free; Services of Relatives. Professional services or supplies received from a person who lives in insured person's home or who is related to insured person by blood or marriage; Voluntary Payment. Services for which insured person is not legally obligated to pay. Services for which insured person is not charged. 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.

- [Download the complete Blue Vision Select summary](#)

Additional benefits

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) provide state employees the opportunity to set aside pre-tax dollars from each paycheck for reimbursement of qualified medical and/or dependent care expenses. This means you can pay for medical and/or dependent care expenses with tax-free money. Eligible employees can enroll during open enrollment.

The state's FSA program is set up and administered through Key Benefits Administrators. The state currently offers three FSAs to employees: Medical Care, Limited Purpose and Dependent Care FSAs.

Flexible Spending Accounts provide another opportunity to set aside pre-tax dollars from each paycheck for reimbursement of qualified medical and/or dependent daycare expenses. You must re-enroll in medical and dependent care flexible spending accounts each year if you wish to continue to participate. If you continue participation in the Medical FSA, do not discard the debit card from Key Benefit Administrators; new cards are not automatically issued each year.

The administrative fee will remain the same at \$2 bi-weekly. As a reminder, FSAs 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.

View enrollment packets for each FSA option at www.in.gov/spd/2705.htm.

Medical Care and Limited Purpose FSAs are front-loaded accounts in which annual contributions are paid back throughout the year out of the employee's biweekly paycheck. Currently, the maximum annual contribution for the Medical Care and Limited Purpose FSAs is \$5,000. Both FSAs are designed to 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.

It is important to note that the Limited Purpose FSA may only be used for dental, vision and preventive care expenses until the minimum deductible of a CDHP is met (Federal regulations set the deductible at \$1,200 for single and \$2,400 for family.). Once the minimum deductible is met, the Limited Purpose FSA can be used for qualified medical expenses. Participation in a Medical Care FSA disqualifies you from participating in a Health Savings Account (HSA) while Limited Purpose FSA coverage is qualified coverage for those also participating in a HSA.

Dependent Care FSAs differ from other FSAs in that they are not front-loaded. Portions of your biweekly pay is put into a pre-tax account to help 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 you are married and filing separate tax returns).

Dependent care costs include fees for adult and childcare centers, pre-school and before and after school care. To be eligible for a Dependent Care FSA you and your spouse (if married) must be employed or attend school and your dependent must be under the age of 13 or physically and/or mentally incapable of caring for him or herself. Dependent care expenses do not include medical expenses and therefore can be used even if you participate in an HSA.

All FSAs have a use-it-or-lose-it rule. Money left at the end of the plan year is not rolled over or reimbursed. You must re-enroll in your FSA each year if you wish to continue to participate. If you decide that an FSA is right for you and your family, it is important to be conservative when allocating the yearly amount. You should only consider known expenses and in the case of the Dependent Care FSA, factor in vacations or times when you will not be paying the dependent care provider. Once you decide your allocation amount, the number can only change if you experience a qualifying event. You may also change your allocation during open enrollment.

Additional Benefits

Life Insurance

How do eligible employees apply?

Eligible, full-time state of Indiana employees may apply for coverage under the group life insurance policy. All applications must be completed and submitted within the employee's initial enrollment period established for the employee's agency, using the state of Indiana's electronic enrollment system.

If employees do not apply for coverage during their initial enrollment period, but wish to apply at a later date, they will be required to first submit evidence of insurability, undergo medical underwriting and receive AUL's written approval prior to receiving coverage.

Please note: Basic life insurance coverage is a prerequisite for approval of supplemental life insurance coverage. Basic life insurance and supplemental life insurance coverages are prerequisites for approval of dependent life insurance coverage.

By completing the Evidence of Insurability process, you can acquire or make changes to your life insurance plans, at anytime throughout the year. Allowable changes include increasing your coverage level and/or adding eligible dependents 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 Evidence of Insurability process includes completing a paper application and, if required, an evaluation by a doctor. To initiate the Evidence of Insurability process you will need to log on to the SPD life insurance page at: www.in.gov/spd/2640.htm. You will need to print, complete and mail the "Group Enrollment Form" and the "Statement of Insurability Form" to American United Life Insurance (AUL). Do not return them to your agency as this may cause delay and/or denial. AUL will then review your paperwork and inform both you and SPD Benefits of their decision. If approved, SPD Benefits will make appropriate changes to your life insurance plans and start the deductions with the Auditor's Office.

If you would like to either decrease your coverage level or drop any of your life insurance plans during open enrollment, you can complete these actions online using PeopleSoft. You can also make changes to your beneficiary information at any point during the year by accessing PeopleSoft Self-Service. Please remember, you are the only one who can make changes to your beneficiary information.

REMINDER: Supplemental life insurance is offered to most employees in increments of \$10,000 up to and including \$150,000, regardless of salary level. Employees reaching age 65 or older on or before Dec. 31, 2011, will be limited to \$100,000 of supplemental life insurance coverage. Employees attaining age 65 during the plan year will automatically be reduced to \$100,000 of supplemental life insurance coverage and their payroll deductions adjusted accordingly.

Life insurance coverages offered by American United Life Insurance Company®(AUL)

For information, please contact:
American United Life Insurance Company
State of Indiana Unit
OneAmerican Square, P.O. Box 368
Indianapolis, IN 46206-0368
1-800-673-3216

Notices

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 are not eligible for insurance or related benefits.

Dependents of eligible employees may be covered under the state's benefit plans. Dependents are defined as:

Spouse: One's wife or husband. An ex-spouse is not eligible for coverage, even if court ordered.

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

Age limitation: Dependent children are eligible for coverage until their 26th birthday.

If the dependent child is both incapable of self-sustaining employment by reason of mental or physical disability and is chiefly dependent upon the employee for support and maintenance prior to age 19, the dependent child's coverage shall continue if satisfactory evidence of such disability and dependency is received within 120 days after child's 26th birthday. Coverage for the dependent will continue until the employee discontinues his coverage or the disability no longer exists.

A dependent child of the employee who attained age 26 while covered under another health care policy and met the disability criteria specified above, is an eligible dependent for enrollment so long as no break in coverage longer than 63 days has occurred immediately prior to enrollment. Proof of disability prior to age 19 and proof of prior coverage will be required. The plan requires annual documentation from a physician after the child's attainment of the limiting age.

Adult relatives: Even in situations where the employee possesses a court order or legal guardianship, adult relatives (e.g. father, mother, aunt, uncle, niece, nephew) do not qualify as dependents and are not eligible for benefits through the state of Indiana except as dependents under the Dependent Care Spending Account.

Qualifying Events

Qualifying events/making changes after open enrollment

After noon (Eastern Standard Time) Monday, Nov. 21, you will not be able to make changes to your benefits. This means you must be certain you have made all the best choices and remembered to add all eligible dependents to all plans.

After Open Enrollment, you can only make changes due to a qualifying event. Qualifying events are governed by the IRS; examples of qualifying events are:

- 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, start or end of an unpaid leave of absence or a change in worksite.
- Changes in dependent eligibility status (such as attainment of limiting age or in the case of life insurance, marriage).

Failure to report the qualifying event and complete any necessary paperwork within 30 calendar days means you will not be able to add dependents until the next enrollment period.

Notices

Dual coverage

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

A second example occurs when an employee who has retired from one area of state employment begins active work in another state position. In this instance, you 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.

Creditable coverage disclosure notice

If you are Medicare-eligible, there are two important things you need to know about your current coverage and Medicare's prescription drug coverage. First, Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare.

Second, the state of Indiana's third party administrator determined that the prescription drug coverage offered by Medco Health Solutions is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you are considering joining Medicare's prescription drug coverage, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. For more information about Medicare's prescription drug coverage please visit: www.medicare.gov.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

CHIPRA is a premium assistance program for employees who are eligible for health coverage from their employer, but are unable to afford the premiums. States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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, you can contact your state Medicaid or CHIP office. You can also call 1-877-KIDS NOW or visit the following website: www.insurekidsnow.gov to find out how to apply. Please review the information posted on the Benefits website for more details.

Notices

Women's Health and Cancer Rights Act (WHCRA) of 1998

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact Anthem at 1-877-814-9709 for more information.

Open Enrollment help

Completing your open enrollment

PeopleSoft log in and online self-service instructions

WHEN TO LOG IN: You can access your Open Enrollment event 24 hours, 7 days a week from Monday, Oct. 31 through noon Monday, Nov. 21 (EST). You may have trouble accessing PeopleSoft during the workday, so if you run into problems, please try again at an off-peak time, such as after 6 p.m. or on the weekend. Keep in mind you can access your Open Enrollment event from any computer that allows you access to PeopleSoft. You will need to locate a PC that operates with Windows/Internet Explorer or a compatible Internet service. If you are using a MAC, you may not be able to complete your online enrollment.

Helpful hints:

1. If you access the state network, the password used to log on to your computer can be used to log in to PeopleSoft.
2. If you do not remember the password used to log in to your computer, you can use IOT's Self-Service Password Reset to reset your password over the phone anytime. Enrollment is required so if you have not enrolled yet, go to www.passwordreset.iot.in.gov to get started.
3. When making your elections in PeopleSoft, do not use the BACK/FORWARD arrow buttons at the top of your web browser.
4. Keep in mind you must turn off your "pop-up blocker" in order to print your Benefit Election Summary.

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

IOT Customer Service can be reached at (317) 234-4357 or toll free at 1-800-382-1095.

Remember, you can access PeopleSoft at any time during the year to review your benefits or update contact information.

- [Link to PeopleSoft](#)

CURRENT BENEFIT ELECTIONS: To view current benefit elections you will need to login to PeopleSoft and follow these steps: Click on Self Service, Click on Benefits and Click on Benefit Summary. Your 2012 benefits will not be available to view until Jan. 1, 2012.

Making the most of your health plan

What's available on the Anthem website?

When you enroll into state benefits, you immediately have access to several Anthem resources for no extra cost. These include:

- 360° Health**
- 24/7 NurseLine**
- ConditionCare**
- Employee Assistance Program (EAP)**
- MyHealth@Anthem**

360° Health

Everybody wants to feel better, be healthier. 360° Health can help you do it.

Whether you're fit and want to stay that way, living with a chronic condition or you fall somewhere in between, 360° Health surrounds you with the support, resources and tools to help you live healthier. Even if you're dealing with several complex health issues at once, experienced nurses work closely with you, your family members and your doctors to help you get back on your feet.

A team of medical specialists backs Anthem's nurses in areas such as pharmacy and nutrition. You can be sure they have access to the most up-to-date information about your treatment options. With 360° Health, everything you need to help you live healthier is in one place - information, guidance and motivation, paired with one of the broadest networks of health care professionals.

This powerful combination has resulted in some great results for Anthem members. According to a recent survey, four out of five people who have used a 360° Health program say their health has improved as a result.

360° Health brings all of the resources, tools and programs Anthem has to offer together in one place to help you and your family members:

- Manage and maintain your health
- Make more informed health care decisions
- Get the most value from the hard-earned dollars you spend on health care
- Feel your best day after day
- No additional cost

Ninety-four percent of members who participated in a 360° Health program say they have more control of their health as a result.

24/7 NurseLine – 1-888-279-5549

NurseLine provides anytime, toll-free access to nurses for answers to general health questions and guidance with health concerns. The nurse can help you understand your symptoms or explain a medical treatment order from your doctor. Every caller receives credible, reliable information from a registered nurse.

A full range of topics are covered. Some of these include: pediatrics issues, digestive problems, bone/muscle/joint problems, cardiovascular issues or dermatology. Callers can also access confidential, recorded messages about hundreds of health topics.

Spanish speaking nurses are available as well as other languages translators and services for the hearing impaired. The NurseLine number is located on the back of your Anthem ID card. Reviews of the program say: "I have such a peace of mind knowing I can call a nurse to figure out if we need to go the ER or not, or for how to help keep my kids comfortable when they are sick. I love this service!"



Making the most of your health plan

What's available on the Anthem website?

Employee Assistance Program (EAP) – 1-800-223-7723

Good health doesn't mean just physical well-being. Emotional wellness is every bit as important. Anthem EAP has an extensive network of licensed behavioral health professionals who can help you address such issues as:

- Relationship or family problems
- Alcohol or drug abuse
- Feelings of overwhelming loss or grief
- Depression or anxiety
- Stress management
- Times of crisis

Anthem EAP services are available to employees and their household members. Anthem's specially trained representatives are available 24 hours a day, 365 days a year, via the toll-free telephone number on your membership card.

Get the support you need. Telephone counseling, crisis assistance, legal and financial referrals and care resources are available 24 hours a day, 365 days a year. Should you require further assistance, Anthem's staff can help you locate the appropriate resources in your community.

Your privacy is important. Your participation is voluntary and confidential. Your friends, family and employer cannot find out about your use of The Easy Program without your written consent. You have access to Anthem's innovative website, AnthemEAP.com for helpful resources and interactive tools, including articles on managing personal and professional situations, self-assessments and dependent care searches.

ConditionCare

This program is designed to help you manage your health if you have asthma, diabetes, Chronic Obstructive Pulmonary Disease (COPD), coronary artery disease or heart failure. The program features access to a Nurse Coach for one-on-one coaching and intervention. You also receive support from a team of health professionals, including dietitians, pharmacists, health educators, social workers and more. Care guides and newsletters are also available for more information.

What are people saying about the program?

- 3 out of 4 members feel more confident about managing their condition after being in the program
- 92% of those who spoke with a nurse-coach rated their experience as "excellent"
- 86% say they're likely to recommend the program to others
- 80% say the program is a trusted resource in helping them care for their health

MyHealth@Anthem – www.anthem.com

Secure, interactive web site provides easily accessible, up-to-date information about diseases, medicines, medical-related procedures and treatments. It also offers a health risk assessment to identify personal risk factors. The site is designed to help employees stay healthy and make more informed choices about their care. To access your information and take a health risk assessment, go to www.anthem.com. If this is your first time using the website, you will need to register and create a new account.

Explanation of Benefits (EOB) Reference Guide

How much do I owe for a medical claim?

Did I meet my deductible yet?

We realize that health care bills can be confusing. We're committed to making sure you have all of the information you need about your health care.

The EOB shows you exactly how your benefits work for every doctor visit and service, how much we pay, and how much you still owe. It also shows how much of your annual deductible is already paid for the year, in case that's not at the top of your list of things to remember.

You may not always receive a hard copy EOB in the mail. For example, if you only need to pay a copay for a doctor visit or other service, we will not mail you an EOB. However, you can still view your medical EOBs/claims recaps online at anthem.com. You can even choose to go completely paperless for all medical EOBs/claims recap statements by selecting "Go Paperless" in your account profile.

Did you know that you can get your medical EOBs online? Here's how.

- Log in to anthem.com (if you haven't registered yet, you will need to register to log in).
- Click on "Profile."
- Scroll down the page to choose how you would like to receive your medical EOBs/claims recaps and select "Go Paperless."*

*Only the subscriber can pick this option.





An independent licensee of the Blue Cross and Blue Shield Association.
Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of KY, Inc.
A Registered Mark of Blue Cross and Blue Shield Association.

THIS IS NOT A BILL

CHECK NUMBER:	N/A
PATIENT:	PATIENT, IMA
PATIENT ACCOUNT #:	
INSURED ID:	ABC123M45678
PROVIDER:	JOHN SAMPLE MD
CLAIM #:	SPECIAL00000
PROVIDER PARTICIPATION STATUS:	OUT OF NETWORK
EOB DATE:	09/19/2006
AMOUNT PROVIDER MAY BILL YOU, IF NOT ALREADY PAID	100.00

6 YOUR BENEFIT SNAPSHOT*			
	BENEFIT AMOUNT	AMOUNT MET-YEAR TO DATE	REMAINING BALANCE
BENEFIT YEAR 2006			
INDIVIDUAL IN-NETWORK DEDUCTIBLE	150.00	150.00	
INDIVIDUAL OUT-OF-NETWORK DEDUCTIBLE	300.00	100.00	200.00
FAMILY IN-NETWORK DEDUCTIBLE	300.00	200.00	100.00
FAMILY OUT-OF-NETWORK DEDUCTIBLE	600.00	100.00	500.00
INDIVIDUAL IN-NETWORK OUT-OF-POCKET-LIMIT	750.00	970.00	200.00
INDIVIDUAL OUT-OF-NETWORK OUT-OF-POCKET-LIMIT	1,500.00	100.00	1,400.00
FAMILY IN-NETWORK OUT-OF-POCKET-LIMIT	1,500.00	1,020.00	480.00
FAMILY OUT-OF-NETWORK OUT-OF-POCKET-LIMIT	3,000.00	100.00	2,900.00
LIFETIME MAXIMUM	5,000,000.00	12,283.32	4,987,716.68

PATIENT, IMA		LKJGHLKH		KLJLYKYUQ		KY 12345						
DATE(S) OF SERVICE	CODES	TYPE OF SERVICE	CHARGE	ALLOWABLE AMOUNT	PROVIDER RESPONSIBILITY	REASON CODE(S)	DEDUCTIBLE	COPAY/ COINSURANCE	ADDITIONAL MEMBER RESPONSIBILITY	REASON CODE(S)	AMOUNT PAID TO PROVIDER	
02/02/2006-02/02/2006	99245	MEDICAL CARE	100.00	100.00	0.00		100.00	0.00	0.00		0.00	
TOTALS			100.00	100.00	0.00		100.00	0.00	0.00		0.00	

AMOUNT MET - YEAR TO DATE INCLUDES EITHER 4TH QUARTER CARRY OVER OR PRIOR CARRIER DEDUCTIBLE. THIS IS AN EXPLANATION OF THE CLAIMS PROCESSED BY ANTHEM FOR BENEFITS PROVIDED TO YOU. REASON CODES, WHEN APPLICABLE, ARE EXPLAINED AT THE BOTTOM OF THE LAST PAGE. IF YOU FILED MULTIPLE PROVIDER BILLS, THEY MAY BE PROCESSED SEPARATELY. CLAIMS FOR EMERGENCY CARE FROM A NON-NETWORK PROVIDER MAY BE APPROVED TO PAY MORE IF YOU RECEIVE A BILL FOR MORE THAN THE ALLOWED AMOUNT. CALL CUSTOMER SERVICE.

IF YOU ARE COVERED BY MORE THAN ONE (1) BENEFIT PLAN, YOU SHOULD FILE ALL YOUR CLAIMS WITH EACH PLAN. THIS CLAIM MAY HAVE BEEN PAID AS IF ANTHEM WERE THE PRIMARY CARRIER. IF YOU HAVE COVERAGE WITH TWO OR MORE PLANS, THE PLANS' COORDINATION OF BENEFITS RULES WILL BE USED TO DETERMINE HOW MUCH EACH PLAN PAYS. PLEASE CONTACT CUSTOMER SERVICE TO UPDATE YOUR OTHER PLAN INFORMATION.

*CLAIMS ARE PROCESSED IN ORDER OF DATE RECEIVED, NOT NECESSARILY IN DATE OF SERVICE ORDER.

This Explanation of Benefits (EOB) statement was developed to assist you in understanding how your claim(s) were processed. This guide will take you through the key elements of the EOB.

- 1. Patient:** The name of the patient who received services.
- 2. Insured ID:** This is the identification number of the subscriber/employee. It is the ID number printed on your Anthem Blue Cross and Blue Shield (Anthem) ID card. Please give us this number if you call or write with questions.
- 3. Provider:** The name of the provider (e.g., physician, hospital or laboratory) who performed the services for the patient. The provider name shown may be different than your physician's name because services such as tests, X-rays and consultations may be provided by other health care professionals or facilities as directed by your physician.
- 4. Claim #:** This is the specific number that refers to this particular claim. Have this number handy when calling Customer Service.
- 5. Amount Provider May Bill You, If Not Already Paid:** The amount of the total billed charges for which you are responsible.
- 6. Your Benefit Snapshot:** Details recent claim activity and gives a snapshot of your health benefit plan. **Note:** *This is just a snapshot. For actual benefits, contact Customer Service or refer to your certificate.*
- 7. Dates of Service:** The from/to dates reported for each service performed for the patient.
- 8. Type of Service:** A general description of each service included in the claim.
- 9. Charge:** The amount billed by the physician, pharmacy, hospital, laboratory or other health care professional who performed each service. **Note:** *If Medicare/ Complementary services are involved, the amount in this column will represent the amount billed to Medicare.*
- 10. Provider Responsibility and Reason Code(s):** This is the amount the provider is responsible to write off which is in addition to any Anthem discounts that may apply to the claim. The codes shown in the column to the right refer to specific message below each claim. These messages clarify the provider responsibility.
- 11. Additional Member Responsibility and Reason Code(s):** This is the amount you are responsible for in addition to any deductible, coinsurance or copayments that may apply to this claim. The codes shown in the column to the right refer to specific message below each claim. These messages clarify a payment situation or explain why you may be responsible for a service.
- 12. Note:** *This column may read Amount Paid to Provider, Amount Paid to Member or Amount Paid to Alternate (e.g., Custodial Parent) depending on who is receiving payment for the claim.*

It pays to shop around.

Be a savvy health care consumer with Anthem Care Comparison.

Compare cost, quality, safety and more at hospitals and facilities

Your health is too important to leave to chance. So we created Anthem Care Comparison to help you make more informed health care choices. For example, the same medical procedure can have different price tags at different hospitals or facilities. Anthem Care Comparison can help you see those differences in advance. You can see cost ranges for different treatments, procedures and hospital stays. We even bundle costs together for a health event, so you get the big picture of its impact on your health — and your wallet.

Of course, cost isn't the only factor you'll want to consider. You want top-notch health care, too. Anthem Care Comparison gives you information on key quality factors such as the number of specific procedures performed, patient safety, facility complication rates, mortality rates and average length of stay.

Talk to your doctor

Your doctor may suggest a certain specialist, hospital or facility for a reason. It's okay to ask why, or to ask about your alternatives. It's also a good idea to talk to your doctor about your research with Anthem Care Comparison. If you find better costs or a better track record somewhere else, tell your doctor. The two of you can use that information to determine the best course of action for you.

Take advantage of a large network of doctors, hospitals and facilities

You have access to one of the largest provider networks in the country through the BlueCard® program. So chances are good that you'll have options to explore without having to go out of network. You have choices — and lower out-of-pocket costs — when you use network doctors and hospitals. It's all about finding what works for you.

Spread the word

Your healthy choices can influence the people around you. How you go about making those choices can make a difference, too. Let your friends and family know that they may have more choice over their health care than they realize.



TRY ANTHEM CARE COMPARISON TODAY
Just log in at anthem.com. Go to your Account Summary page and select "Compare Facility Cost and Quality".



Find MyHealth@Anthem on anthem.com

Good health means something different to everyone. From ramping up your workout to snuffing out cigarettes, MyHealth@Anthem on anthem.com can help you improve your health outlook. Find the information, tips and tools you need to help you take control of your health — and make smart health care decisions.

Plot your course

MyHealth Assessment prompts you to take an honest look at your health. Receive a personalized health profile and read a doctor's summary of your results. Get acquainted with your personal risk factors and get specific action steps you can take to help reduce your risks - and improve your health.

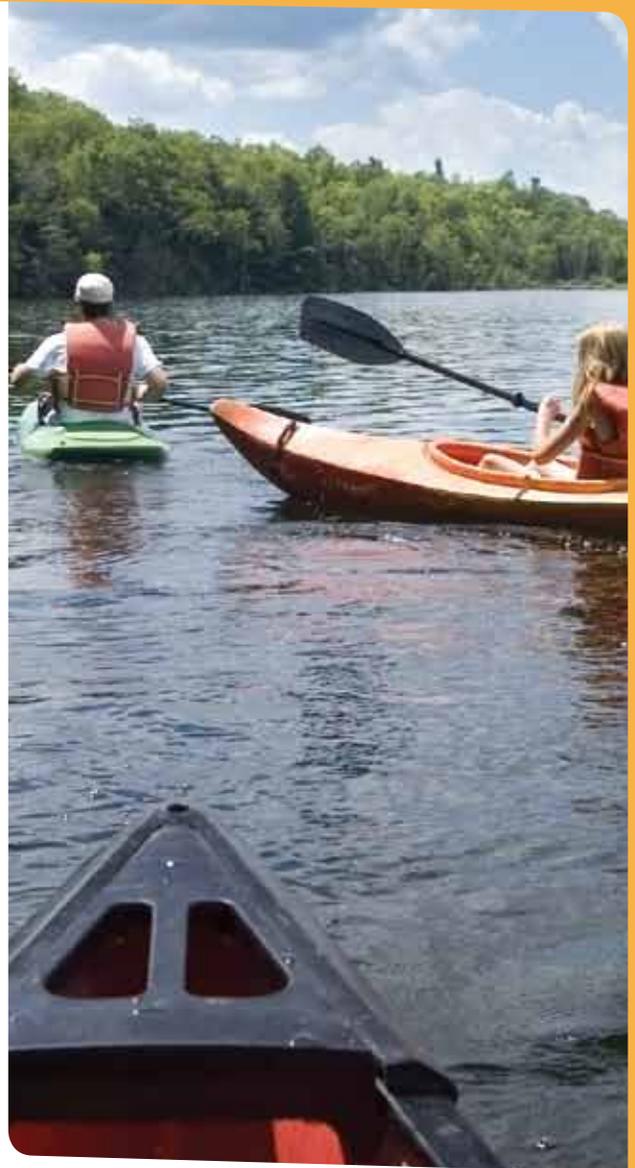
Create a new record

MyHealth Record lets you access and manage your records — privately and securely — over the Internet. View your medical claims. Find your records in one convenient, well-organized place. Keep track of when you're due for health screenings. Many members have relied on MyHealth Record to help share health information with caregivers away from home or during emergencies.

Find help along the way

Stressed out? Battling the bulge? Trying to get a grip on cholesterol? **The Lifestyle Centers** point you to the information that matters to you. Find the support that can help you make important changes — or stay on top of chronic concerns. Not sure where to begin? Check the recommendations at the end of your MyHealth Assessment. They're based on your answers. Your health. Your life.

Find the information, tips and tools you need to help you take control of your health — and make smart health care decisions — at MyHealth@Anthem. Read a little about some popular tools on the back. Then check them out for yourself online at anthem.com.



Stay on track

MyHealth@Anthem comes loaded with tools that make it easy (maybe even fun) for you to keep tabs on your health. These guideposts help keep you informed and inspired.

- *Use Health Trackers* to gauge key measures like your cholesterol, blood pressure — even your weight and waist measurements.
- *Health Topics*: Browse and review information on more than 100 health and wellness topics. From children's health to life after 50. Allergies to women's health. You're bound to find it here.
- *Kick the habit* — at your own pace — with the smoking cessation program.
- *Use The Symptom Checker* to dig up clues about what could be causing those aches, pains and twinges.
- *Make more informed decisions with the interactive tools*. Compare hospitals. Research conditions and procedures. Estimate treatment costs, check for potential drug interactions and more.
- *Find information and support* — anonymously — at our Online Communities. Connect with people you can relate to, who are going through similar experiences. Discuss issues like: smoking, pregnancy, diabetes, depression, diet and nutrition, and many other topics.
- *Exercise Program*, whether you're a current couch potato or an elite athlete. This interactive program — created by an Olympic coach — is like having a personal trainer 24/7. Set goals and track your improvements. Get personalized exercise plans that adjust as your routines change. Stay motivated. Try it!

Although you can combine these tools any way you want to create your own health solution, here's an easy way to get started.

1. Simply log in to [anthem.com](https://www.anthem.com).
2. Click on "Health & Wellness".
3. Begin your health assessment.

There's more to MyHealth@Anthem than we could ever cover here. The only way to discover all the ways it can help you is to log in and start exploring.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado and Nevada: Rocky Mountain Hospital and Medical Service, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: 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 Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. 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. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Ohio: Community Insurance Company. In Virginia (serving Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123.): Anthem Health Plans of Virginia, Inc. 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. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM and 360° Health are registered trademarks 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.

Chart a healthy course with MyHealth Record at anthem.com

Are you due for a tetanus shot? A routine cancer screening? An annual checkup? Your health information is always at your fingertips with MyHealth Record. Store all of your health records — easily and securely — in one convenient spot at anthem.com. Keep track of medical appointments, preventive care, claims, medications and more.

Organized. Secure. Accessible.

Even if your medical records are well-organized at home, keeping them private — yet always available — are still concerns. MyHealth Record keeps your health information organized, secure and easily accessible, which is especially important in emergencies. Your records will be available to help guide your care — wherever you are — with life-saving potential.

You can use MyHealth Record to:

- Consolidate your health history in one secure location.
- Track doctor visits, vaccinations and other wellness services — a great help if you see multiple doctors.
- Print out and share your health summary with your physicians. It could identify an important detail or quickly update a new doctor on your medical history.
- Stay on top of the latest patient education, health management programs, health news and tools with your customized health profile — so you can make better-informed health care decisions.
- Help avoid potentially dangerous drug interactions, medicines you're allergic to, or duplicative tests and procedures.

Where does the information come from?

Enroll in MyHealth Record and you can add your own information, including:

- Dates of immunizations, cancer screenings, cholesterol tests
- Dates of surgeries and the names of hospitals where they were performed
- A list of allergies
- Prescription and over-the-counter drugs you are taking
- In-office lab tests (such as Strep)
- Serious or chronic medical conditions



We can even update your record weekly with any new claims information on file.*

Create your own emergency health card

Use your MyHealth Record information to create your own Emergency Information Card. This wallet-sized card summarizes your key health information, such as your blood type, allergies and medical conditions. Always carry it with you to help ensure you get the right care in the event of an emergency. Or use it anytime a health care professional needs a quick overview of your medical history.

*The types of data supplied will vary depending on your health plan and may not be complete (for instance, claims that may not have been received or posted).

YOUR RECORD IS PRIVATE

As always, your personal health information will be safeguarded with our strict privacy and security standards. You can view these standards at MyHealth@Anthem at anthem.com. There is no obligation to participate, and you can deactivate the service at any time.

BEGIN YOUR MYHEALTH RECORD TODAY

1. Just log in to anthem.com.
2. Click on "Health & Wellness".

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado and Nevada: Rocky Mountain Hospital and Medical Service, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: 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 Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. 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. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Ohio: Community Insurance Company. In Virginia (serving Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123.): Anthem Health Plans of Virginia, Inc. 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. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM and 360° Health are registered trademarks 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.



Your Wellness Exam

For most people, annual physicals have been replaced by periodic wellness exams based on age and general health. While it may be tempting to think of these visits as optional, they provide a unique opportunity for exchanging vital information with your doctor.

A physical exam gives your doctor a basis for comparison as your physical condition changes with age – and it gives you the chance to ask questions and build a relationship with your doctor.

During your checkup, you should expect both conversational probing and physical screenings for various conditions, as well as more general tests for body mass index (BMI) and to spot hearing loss or visual impairment.

Together, these screenings represent a shift in focus from early diagnosis to prevention.¹ Your doctor wants to identify high-risk behaviors to help you maintain wellness and avoid more serious health problems. As part of this goal, he or she may also administer tetanus-diphtheria, influenza and pneumococcal immunizations.²

And if your family history or recent symptoms send up any red flags, your doctor may recommend additional testing.

What to expect

Most doctors spend a good portion of the wellness appointment counseling patients about ways to improve their health. After taking a thorough history and asking about any specific problems, the doctor generally will discuss:²

- Your dietary habits and how to improve them
- The amount of physical activity you should be getting
- Any stress in your life or symptoms of depression
- Tobacco, alcohol and recreational drug use
- Safety precautions like seat belt use and helmet use for cyclists
- Your sexual habits and any risks they pose
- How to protect yourself from the sun
- The need for regular eye exams
- Any medications you are taking
- Recommended screening tests and immunizations for your age, and risk factors for disease

Recommended screenings follow a flexible schedule, which can change depending on your health and family history. Here are some recommendations from the U.S. Preventive Services Task Force.^{3,4}

General Recommendations

Screening	How Often?
Blood pressure	At least every two years for adults 18 and older
Cholesterol	Regular screenings beginning at age 35 for men and 45 for women – or younger if you have risk factors like diabetes, high blood pressure, family history of heart disease or you're a smoker
Skin Exam	Self-exams at least annually; talk to your doctor about screening, particularly if you're fair-skinned or spend a lot of time outside
Diabetes	Regular tests if you have high blood pressure or high cholesterol; talk to your doctor about other risk factors

Women

Screening	How Often?
Mammogram	Every one to two years for women 40 and older, with or without a breast exam
Pap test	Every one to three years if you are sexually active and between the ages of 21 and 70
Osteoporosis	Screen routinely starting at age 65, or starting at age 60 for women with risk factors (like a small frame or weight of 154 pounds or less)
Chlamydia	Routine screening for all sexually active women age 25 and younger; talk to your doctor about screenings for other sexually transmitted diseases

Men

Screening	How Often?
Colorectal cancer	Starting at age 50; talk to your doctor about the right test for you
Sexually transmitted diseases	Talk to your doctor about how often
Abdominal aortic aneurysm	Once between ages 65 to 75 if you have ever smoked

Making the most out of your medical exam

Because doctor visits can be very short, it's in your best interest to come prepared. Patients who are active and involved in their own health care decisions get better results – so get involved!

You should expect your doctor to have reviewed your chart before your appointment, so he or she is aware of anything you've been treated for in the past and the medications you're taking. It's reasonable to expect your doctor to know who you are and to form some sort of relationship with you.

Before your visit, write down important information about your family and medical history – especially any information that might have changed since your last visit. Make a list of all the medications you're taking, along with specific dosage information. Also, write down any concerns you have about your health, or any new symptoms you're experiencing.²

To ensure that your doctor is on time and not rushed, make an appointment as early in the day as you can, and bring a family member or friend if you're worried you might not remember or understand the doctor's recommendations. Another person can help you remember your concerns, or ask important questions you're too distracted to think of. Also, a friend or family member can take notes so you remember when to expect test results and what your next steps are.

Your wellness visits are an important step toward maintaining your health, so do what it takes to make the most of them.

Visit anthem.com for more ways to get healthy – and stay healthy.



Sources:

- Centers for Disease Control and Prevention website: cdc.gov/family/checkup/index.htm#prepare, "Regular Check-Ups are Important," May 2008.
- Centers for Disease Control and Prevention website: cdc.gov/family/checkuplist/index.htm, "Check-Up Checklist: Things to Do Before Your Next Check-Up," May 2008.
- Centers for Disease Control and Prevention website: ahrq.gov/ppip/healthymen.htm, "Screening Tests for Men: What You Need and When," February 2007.
- Centers for Disease Control and Prevention website: ahrq.gov/ppip/healthywom.htm, "Screening Tests for Women: What You Need and When," February 2007.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado and Nevada: Rocky Mountain Hospital and Medical Service, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: 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 Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. 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. In New Hampshire: Anthem Health Plans of New Hampshire, 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 Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWI"), which underwrites or administers the PPO 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 POS 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.

MANSH0314ABS 9/09 F0063447

Carrier Contact Information

Addresses, phone numbers and websites

Company	Phone number	Website
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 Delta Dental P. O. Box 30416 Lansing, MI 48909-7916	Customer Service: 1-800-524-0149	www.deltadentalin.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 Tower Bank 116 East Berry Street Fort Wayne, IN 46802	Customer Service: 1-888-472-8697	www.towerbank.net Employer Code # 100366
Prescription Program Medco 525 West Monroe St, Ste 2350 Chicago, IL 60661	Customer Service: 1-877-841-5241	www.medco.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 American United Life Insurance, Co Attn: Group State of Indiana Unit P. O. Box 368 Indianapolis, IN 46206-0368	Customer Service: 1-800-673-3216	www.employeebenefits.aul.com

State Personnel Department Benefits Hotline
7:30 a.m. to 5 p.m. Monday through Friday, EST

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

Glossary

Important terms

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)

Dependents of eligible employees may be covered under the state's benefit plans and are defined as:

1. Spouse: Employee's wife or husband (as recognized by Indiana law). An ex-spouse is not eligible for coverage, even if court ordered.
2. Children: Natural-, step-, foster or legally adopted children; children who reside in the employee's home for whom the

employee or spouse has been appointed legal guardian or awarded legal custody by a court, under the age of 26.

3. Age limitation: Dependent children are eligible for coverage until their 26th birthday.
4. Disabled dependent: If the dependent child is both incapable of self-sustaining employment by reason of mental or physical disability and is chiefly dependent upon the employee for support and maintenance prior to age 19, the dependent child's coverage shall continue if satisfactory evidence of such disability and dependency is received within 120 days after child's 26th birthday. Coverage for the dependent will continue until the employee discontinues his coverage or the disability no longer exists.

A dependent child of the employee who attained age 26 while covered under another health care policy and met the disability criteria specified above, is an eligible dependent for enrollment so long as no break in coverage longer than 63 days has occurred immediately prior to enrollment. Proof of disability prior to age 19 and proof of prior coverage will be required. The plan requires annual documentation from a physician after the child's attainment of the limiting age.

Adult relatives: Even in situations where the employee possesses a court order or legal guardianship, adult relatives (e.g. father, mother, aunt, uncle, niece, nephew) do not qualify as dependents and are not eligible for benefits through the state of Indiana - except under the Dependent Care Spending Account.

Dependent Care (Flexible Spending Account)

FSA established to pay for certain expenses to care for the dependents of an employee while working (if 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. See Dependents to determine those eligible. 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 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.

(Continued on page 43)

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.

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, but are 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 – dependent reaches age 26 or obtains own health insurance

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 \$5,000.

Formulary

List of drugs your health plan covers; may include both generic and brand-name drugs.

Front-load (HSA)

Large 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 25 pay periods. See *Health Savings Account* for 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 \$3,100; for family coverage, the limit is \$6,250. 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 participate in the insurance plan's provider network.

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

(Continued on page 44)

disease or condition that is immediately possible. This 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

Alternative 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.

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. Use of tobacco is considered the use of any product containing nicotine. The incentive is only available to employees enrolled in medical coverage.

If an employee accepts the Non-Tobacco Use Incentive during Open Enrollment and later uses tobacco, that employee will be terminated. The only exception to the job loss penalty is if the employee rescinds the agreement by logging in to PeopleSoft and completing the self-service process to change 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 2012, open enrollment is Oct. 31 through noon Nov. 21 (EST). Changes you make during Open Enrollment take effect Jan. 1, 2012.

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. 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. 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

First day coverage under the insurance plan ends.

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.