2014 BENEFITS
OPEN ENROLLMENT
OCT 30 - NOV 20, 2013 (BY NOON EST)

Call the Benefits Hotline with questions
Monday – Friday, 7:30am – 5:00pm EST:

Indianapolis area 317-232-1167
Outside Indianapolis 1-877-248-0007 (Toll-Free)

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

Webinars will be available to learn more about your 2014 benefit options.

DEADLINE IS **WEDNESDAY,** NOV 20th

Invest In Your Health

@INSPDBenefits

www.in.gov/spd/openenrollment

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Introduction to 2014 Benefits

The Open Enrollment period for 2014 benefits begins Wednesday, October 30. We are pleased to report that the participation of our members in the Consumer Driven Health Plans (CDHP) and the introduction of various Invest in Your Health sponsored programs has had a positive impact on our experience. While healthcare costs across the country continue to rise, the state's projected health plan costs are below the national average.

Our healthcare costs are expected to increase $17 million in 2014, ***$11 million*** less than last year. A large portion of this increase can be attributed to the Affordable Care Act (ACA), which adds more than $4 million of costs and fees to our plan in 2014. Health service providers and employers have been preparing for the impact of the ACA, and our plans have already absorbed more than $2 million in meeting the new requirements. The state will once again contribute 50% of the increase in plan costs, or $8.5 million. Even with these increases, by being better consumers and making healthier choices, our savings are evident and can only improve.

Last year at Open Enrollment, we previewed Castlight, our new cost and quality transparency tool to allow our member to be better consumers. Making good consumer choices means better health outcomes and lower costs for you. Since the implementation of Castlight on June 3, nearly 20% of households have registered. Castlight has allowed our employees to find the best price and the quality rating for that provider and facility...all this while simultaneously providing up-to-date deductible spending incurred during your benefit plan year. If you haven't signed up for Castlight now, visit www.mycastlight.com/soi to start shopping for the best options in health care.

In addition to shopping for health care, we want to encourage you to continue to be an advocate for your health. Our lifestyle choices have the greatest correlation to our well-being. When we shop for healthy foods and seek out ways to increase our physical activity, we reduce our risks for a number of diseases including diabetes and heart disease. This Spring, the State implemented Healthy Lifestyles, an online health tracking tool, to help employees identify and manage health concerns. Visit www.myhealthylifestyles.com to sign up. Another resource is Anthem's website, which offers a variety of services including a wellness tool kit, tips for improving your health and discounts on fitness centers and treatments. Register as a member on www.Anthem.com to access these resources and don't forget to check out the Employee Assistance Program's website at www.AnthemEAP.com.

We know that keeping track of so many different programs can be a challenge. To make it easier, we have created InvestinYourHealthIndiana.com to be your one-stop-shop destination for health and wellness questions. This site is updated year-round with blog posts, articles and information to assist you in your healthcare journey. Links to each Invest in Your Health program are also included in an easy to find format. Our benefits/wellness team continues to research tools and programs to help improve the health and wellbeing of all employees.

On a final note, we would like to remind everyone that hasn't already, to consider moving to one of the CDHPs. CDHP participant medical claims, including those incurred by the member, are 67% lower than the claims for Traditional PPO participants on a per member, per month basis. In addition to the lower cost, CDHP participants are reaping the benefits of health savings accounts (HSA). Since 2006, when the state initiated CDHPs, the state has deposited $222 million into employee accounts. As of August 2013, state employees

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Introduction to 2014 Benefits

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had a healthy balance of $61 million in their HSAs. Explore this opportunity during the 2014 open enrollment to maximize the state's contribution to your healthcare savings.

The highlights of the 2014 benefits include:

Carefully read the open enrollment communication, study the options, discuss the decisions with your spouse if you carry family coverage and take advantage of the resources available to you. The decisions you make during open enrollment impact you and your family for the next year.

The highlights of the 2014 benefits include:

- Three healthcare plans (two CDHPs and one Traditional PPO)
- Non-tobacco use incentive is $35 per pay period
- A new life insurance carrier (Minnesota Life Insurance Company) and rates for 2014
- Dental and vision plans and rates remain the same
- The Medical Flexible Spending Account contribution limit remains at $2,500 as required by the Affordable Care Act
- For CDHP participants with an HSA, the state continues to contribute 45 percent of the CDHP deductible into the HSAs. Once again, the state front loads the accounts by depositing one-half of its contribution into each open HSA on the first pay of 2014. The remaining contributions by the state are divided into equal payments and spread out over the first 26 pay dates in the year. Total contributions by the state are:
    - HSA1 -- $1,123.20 (single); $2,249.52 (family
    - HSA2 -- $673.92 (single); $1,347.84 (family)

Maximum personal costs calculations*

Single Coverage	CDHP1	CDHP2	Traditional PPO
Premium	$310.44	$1,422.72	$4,647.24
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	$3,187.24	$3,748.80	$7,147.24
Family Coverage	**CDHP1**	**CDHP2**	**Traditional PPO**
Premium	$992.16	$4,109.04	$13,138.21
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	$6,742.64	$8,761.20	$18,138.32

*Examples assume employee is participating in the non-tobacco use incentive, using in-network providers and has an open HSA account. These comparisons represent the worst case scenario, which would include the premium costs, deductible and maximum out-of-pocket expenses for 2014.

A guide to a successful Open Enrollment

Open Enrollment checklist

- [ ] Educate yourself about changes occurring Jan. 1, 2014.
- [ ] 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, phone number.
- [ ] Update or confirm your ethnic group.
- [ ] Review your eligible dependents and beneficiaries. You will need to enroll all eligible dependents in each chosen medical, dental and vision 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, you will need to enter your annual contribution amount.
- [ ] If you have a Flexible Spending Account, you will need to re-elect or re-state your annual contribution amount.
- [ ] Accept or decline the Non-Tobacco Use Agreement for 2014.
- [ ] Be sure to print an Election Summary after you have submitted your elections.

Help Sessions are available

Have questions? Need more help?

For 2014 plan summaries, rates, PeopleSoft instructions and other Open Enrollment information, please log onto www.in.gov/spd/openenrollment.

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

- October 30 to November 8 -- 8 a.m. to 3 p.m.
- November 12 to November 15 -- 8 a.m. to 4 p.m.
- November 18 to November 19 -- 8 a.m. to 5 p.m.
- Wednesday, November 20 -- 8 a.m. to noon

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).
email: SPDBenefits@spd.in.gov

A guide to a successful Open Enrollment

Completing Your Open Enrollment

WHEN TO LOG IN: You can access your Open Enrollment event 24 hours, seven days a week from **Wednesday, Oct. 30 through noon Wednesday, Nov. 20 (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. **Note**: PeopleSoft works on OS X (all Safari, Chrome, Firefox versions work); with Windows (all Firefox and Chrome versions work). For Internet Explorer only versions 7,8 and 9 are certified, while IE10/11 do not work.

Helpful hints:

1. If you access the state network, the password used to log on to your computer can be used to log into PeopleSoft.
2. If you do not remember the password used to log into 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 https://myweb.in.gov/IOT/PasswordResetEnrollment 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 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. To access PeopleSoft, open a Web browser window and go to:

https://hr85.gmis.in.gov/hr91prd/signon.html

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 2014 benefits will not be available to view until Jan. 1, 2014.

Effective Dates

Health, dental, vision, life insurance, Health Savings Accounts and Flexible Spending Accounts changes/enrollments will be effective Jan. 1, 2014.

Deductions for health, dental, vision and life insurance will begin:
Payroll A: Dec. 18, 2013 (10 days at old plans & rates; 4 days for new plans & rates)
Payroll B: Dec. 24, 2013 (3 days at old plans & rates; 11 days for new plans & rates)

Deductions for the Flexible Spending Accounts and Health Savings Accounts will begin on the following dates:
Payroll A: Jan. 15, 2014
Payroll B: Jan. 8, 2014

Reminder: Employees on payroll A will not have 2013 FSA or HSA contributions on Dec. 31, 2013.

Education sessions

Information sessions

We hope that you have taken time to log onto the 2014 Open Enrollment website (www.in.gov/spd/openenrollment) and get better acquainted with options for your 2014 benefits.

If you still have questions, we have a few resources outside the Open Enrollment website to help get you the answers you need, including 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 current schedule at www.in.gov/spd/2798.htm.

Webinars

To join a webinar session, visit **http://www.webinar.in.gov/spd2014/**.

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 are still allowed to join after it begins; however, we encourage you to join ahead of time so you don't miss any information. Make sure your computer speakers are turned on and at a comfortable level to hear the presenter. You are able to ask questions through the "chat" feature, which will be shown on the left side of the screen.

View the current webinar schedule at www.in.gov/spd/2798.htm.

Carrier Fairs

Benefit provider representatives are available to answer your questions. Each session lasts two hours.

Monday, October 21 at 11 a.m.
IGC-North Cafeteria
402 W Washington St
Indianapolis, IN 46204

Tuesday, October 22 at 11 a.m.
IGC-South Cafeteria
402 W Washington St
Indianapolis, IN 46204

Wednesday, October 23 at 3 p.m.
Larue Carter Hospital
2601 Cold Spring Rd
Indianapolis, IN 46222

Monday, October 28 at 10 a.m.
Miami Correctional Facility
3038 W 850 S
Bunker Hill, IN 46914

Tuesday, October 29 at 10 a.m.
Logansport Juvenile Facility
1118 Indiana 25
Logansport, IN 46947

Wednesday, October 30 at 10 a.m. (CST)
Indiana State Prison
1 Park Row St
Michigan City, IN 46360

Thursday, October 31 at 10 a.m. (CST)
Westville Correctional Facility
5501 S 1100 W
Westville, IN 46391

Tuesday, November 5 at 1 p.m.
Wabash Valley Correctional Facility
6908 S Old US Highway 41
Carlisle, IN 47838

Non-Tobacco Use Incentive

Save money and your health by going tobacco-free

For 2014, the state is again offering a $35 reduction in health plan premiums to each employee who agrees to not use tobacco during the year.

Non-tobacco use incentive

While you are completing open enrollment for your 2014 health benefits, you will have the option to select the Non-Tobacco Use Agreement. If you select this, that means you will not use any tobacco products throughout 2014 and agree to nicotine testing. The testing is conducted at random, so there is no knowledge of when to expect the procedure.

To receive the $35 incentive, an employee must be tobacco-free by Jan. 1, 2014, and continue so through the calendar year. If you currently use tobacco, but plan to quit and select the agreement, you would be wise to stop using tobacco now.

The use of tobacco includes all forms – smoking or smoke-free (chewing, crushing tobacco leaves and sprinkling on food, etc.). If you sign the agreement and then later use tobacco, your employment with the state will be terminated.

The agreement does not carry over, so if you want the 2014 incentive, you need to complete the Non-Tobacco Use Agreement during open enrollment. The incentive is available only to state employees who have enrolled in medical coverage.

Anyone interested in getting help to become tobacco free, log onto or call Quit Now Indiana: www.quitnowindiana.com or call 1-800-QUIT-NOW (1-800-784-8669). This is a free service.

Health plans for 2014

Summary of Plans and Rates

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 Express Scripts. 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

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 2014 Rates

Plan	Coverage	Bi-Weekly Employee Rate	Bi-Weekly Employer Rate	Bi-Weekly 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	$46.94	$173.28	$220.22	$477.14	$486.69	$1,220.44	$4,505.28	$1,123.20	$5,628.48	$6,848.92
	Family	$73.16	$518.58	$591.74	$1,282.10	$1,307.75	$1,902.16	$13,483.08	$2,249.52	$15,732.60	$17,634.76
CDHP 1 W/ Non-Tobacco Use	Single	$11.94	$173.28	$185.22	$401.31	$409.34	$310.44	$4,505.28	$1,123.20	$5,628.48	$5,938.92
	Family	$38.16	$518.58	$556.74	$1,206.27	$1,230.40	$992.16	$13,483.08	$2,249.52	$15,732.60	$16,724.76
CDHP2	Single	$89.72	$190.56	$280.28	$607.27	$619.42	$2,332.72	$4,954.56	$673.92	$5,628.48	$7,961.20
	Family	$193.04	$553.26	$746.30	$1,616.98	$1,649.32	$5,019.04	$14,384.76	$1,347.84	$15,732.60	$20,751.64
CDHP 2 W/ Non-Tobacco Use	Single	$54.72	$190.56	$245.28	$531.44	$542.07	$1,422.72	$4,954.56	$673.92	$5,628.48	$7,051.20
	Family	$158.04	$553.26	$711.30	$1,541.15	$1,571.97	$4,109.04	$14,384.76	$1,347.84	$15,732.60	$19,841.64
Traditional PPO	Single	$213.74	$216.48	$430.22	$932.14	$950.79	$5,557.24	$5,628.48	$0.00	$5,628.48	$11,185.72
	Family	$540.32	$605.10	$1,145.42	$2,481.74	$2,531.38	$14,048.32	$15,732.60	$0.00	$15,732.60	$29,780.92
Traditional PPO W/ Non-Tobacco Use	Single	$178.74	$216.48	$395.22	$856.31	$873.44	$4,647.24	$5,628.48	$0.00	$5,628.48	$10,275.72
	Family	$505.32	$605.10	$1,110.42	$2,405.91	$2,454.03	$13,138.32	$15,732.60	$0.00	$15,732.60	$28,870.92
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

Employees participating in the CDHP plans are reminded that they must open an HSA account in order to receive the State's HSA contribution.

HSA Accounts	Coverage	Initial Contribution*	Bi-Weekly 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 an CDHP plan effective between 1/1/14 thru 6/1/14 and with an open HSA account. CDHP plans effective after 6/1/14 but before 12/1/14 and with an open HSA account will receive 1/2 of the initial contribution.

Health plans for 2014

CDHP 1 At A Glance

State of Indiana - Consumer-Driven Health Plan 1
Blue Access℠ for Health Savings Accounts
Summary of Benefits, Effective January 1, 2014

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: • 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 • 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 • **Emergency Room services @ hospital (facility/other covered services)** • **Urgent Care Center services**	20% 20%	20% 20%
Maternity Services	20%	40%
Inpatient and Outpatient Professional Services Include but are not limited to: • 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 • Surgery and administration of general anesthesia	20%	40%
Other Outpatient Services *(including but not limited to):* • 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) **(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%
• Hospice care • Ambulance services	20%	20%

Health plans for 2014

CDHP 1 At A Glance

Covered Benefits	Network	Non-Network
Outpatient Therapy Services **(Combined network and non-network limits apply)** • Physician Home and Office Visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility • 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 Abuse**[1] • Inpatient facility services • Physician home and office visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility **Authorization of all inpatient psychiatric and substance abuse services is required. If authorization is not obtained, benefits will not be allowed.**	20%	40%
Human Organ and Tissue Transplants[2] • Acquisition and transplant procedures, harvest and storage	20%	40%

Prescription Drug Coverage – THIS COVERAGE IS ADMINISTERED BY EXPRESS SCRIPTS[3]

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

	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.*
- *Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.*
- *Skilled Nursing Facility – limited to 100 days.*

[1]*We encourage you to contact our mental health subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.*
[2]*Kidney and cornea are treated the same as any other illness and subject to the medical benefits*
[3]*PRESCRIPTION BENEFITS ADMINISTERED BY EXPRESS SCRIPTS. ANY QUESTIONS RELATED TO RX NEED TO BE DIRECTED TO* ***(877)841-5241***

Precertification:

- *Members are encouraged to 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.

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 2014

CDHP 2 At A Glance

State of Indiana - Consumer-Driven Health Plan 2
Blue Access℠ for Health Savings Accounts
Summary of Benefits, Effective January 1, 2014

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: $1,500 Family: $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.* Out-of-Pockets are combined network and non-network; includes the deductible	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: • 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 • 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 • **Emergency Room services @ hospital (facility/other covered services)** • **Urgent Care Center services**	20% 20%	20% 20%
Maternity Services	20%	40%
Inpatient and Outpatient Professional Services Include but are not limited to: • 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 • Surgery and administration of general anesthesia	20%	40%

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An independent licensee of the Blue Cross and Blue Shield Association.
®Registered marks Blue Cross and Blue Shield Association.

Health plans for 2014

CDHP 2 At A Glance

Covered Benefits	Network	Non-Network
Other Outpatient Services *(including but not limited to):* • 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) **(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%
• Hospice care • Ambulance services	20%	20%
Outpatient Therapy Services **(Combined network and non-network limits apply)** • Physician Home and Office Visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility • 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 Abuse**[1] • Inpatient facility services • Physician home and office visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility **Authorization of all inpatient psychiatric and substance abuse services is required. If authorization is not obtained, benefits will not be allowed.**	20%	40%
Human Organ and Tissue Transplants[2] • Acquisition and transplant procedures, harvest and storage	20%	40%

Prescription Drug Coverage – THIS COVERAGE IS ADMINISTERED BY EXPRESS SCRIPTS[3]

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

	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.*
- *Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.*
- *Skilled Nursing Facility – limited to 100 days.*

[1]*We encourage you to contact our mental health subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.*
[2]*Kidney and cornea are treated the same as any other illness and subject to the medical benefits*
[3]*PRESCRIPTION BENEFITS ADMINISTERED BY EXPRESS SCRIPTS. ANY QUESTIONS RELATED TO RX NEED TO BE DIRECTED TO* ***(877)841-5241***

Precertification:

- *Members are encouraged to 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 2014

Traditional PPO

State of Indiana - Traditional PPO
Blue Access℠ (PPO)
Summary of Benefits, Effective January 1, 2014

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: • 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 • 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		
• **Emergency Room services @ hospital (facility/other covered services)**	30%	30%
• **Urgent Care Center services**	30%	30%
Maternity Services	30%	50%
Inpatient and Outpatient Professional Services Include but are not limited to: • 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 • Surgery and administration of general anesthesia	30%	50%

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Health plans for 2014

Traditional PPO

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Outpatient Therapy Services **(Combined network and non-network limits apply)** • Physician Home and Office Visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility • Physical therapy: 25 visits • Occupational therapy: 25 visits • Manipulation therapy: 12 visits • Speech therapy: 25 visits	30%	50%
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Human Organ and Tissue Transplants[2] • Acquisition and transplant procedures, harvest and storage	30%	50%

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Notes:

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- *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 allow amount. However, when choosing a non-network provider, the member is responsible for any balance due after the plan payment.*
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[1] *We encourage you to contact our mental health subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.*

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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 a 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 Savings Accounts (HSA)

Using your HSA

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.

An 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 prefunds the account and makes 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.

State contribution to health savings accounts in 2014

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

**ER = employer contribution*

With an 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.

Updated for calendar year 2014: There are federal guidelines for HSAs, including contribution limits. For 2014, the maximum that can be contributed to an HSA is $3,300 for single coverage and $6,550 for family coverage. This includes contributions made by the employee and the state. For account holders 55 years of age and older, an additional $1,000 can be contributed.

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.

Qualifying for an HSA

To be an eligible individual and qualify for an HSA, you must meet the following requirements:

- You must be covered under a consumer driven health plan (CDHP), on the first day of the month.
- You have no other health coverage except another qualified CDHP.
- You are not enrolled in Medicare (Part A or B).
- You cannot be claimed as a dependent on someone else's tax return.

- IRS Publication 969

2014

The HSA Authority™
Your HSA Partner

Education & Enrollment Packet

HSA Basics

A health savings account (HSA) is a tax-advantaged checking account that gives you the ability to save for future medical expenses or pay current ones. It is individually owned; however, you may elect to designate an authorized signer who may also 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 (FSA);
- Cannot be claimed as a dependent on another person's tax return;
- May not be enrolled in Medicare, Medicaid, or Tricare;
- Must not have used VA 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 2014 are:

- Individual: $3,300
- Family: $6,550

Individuals 55 and older can make an additional catch-up contribution of $1,000 in 2014. A married couple can make two catch-up contributions if both spouses are eligible. The spouses must deposit the catch-up contributions into separate accounts.

The annual maximum contribution is based on a calendar year and there is no limit to the dollar balance that can build in the account over time. Contributions can come from:

- Employee pre-tax payroll withholding
- Employer contributions (non-taxable income)
- Individual contributions from account owner or other individual (tax-deductible for account holder)
- IRA or Roth IRA rollover

Distributions from your HSA

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

Advantages of an HSA

Portability:

You can take 100% of the deposited funds with you when you retire or change employers. You are the account owner.

Flexibility:

You can choose whether to spend the money on current medical expenses or you can save your money for future use. Unused funds remain in the account from year to year and there is no "use it or lose it" provision.

Tax Savings:

- Contributions are tax free, (pre-tax through payroll deductions or tax deductible)
- Earnings are tax free
- Funds withdrawn for eligible medical expenses are tax free.

Premium Savings:

An HSA-qualified insurance plan tends to be less expensive than a traditional insurance plan.

Allowable Expenses

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

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

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

Examples of Allowable Expenses:

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

Non-Allowable Expenses

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

Costs associated with non-medically necessary treatments 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.

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

Examples of Non-Allowable Expenses:

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

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

Opening Your HSA Online

You'll need the following information when you begin:

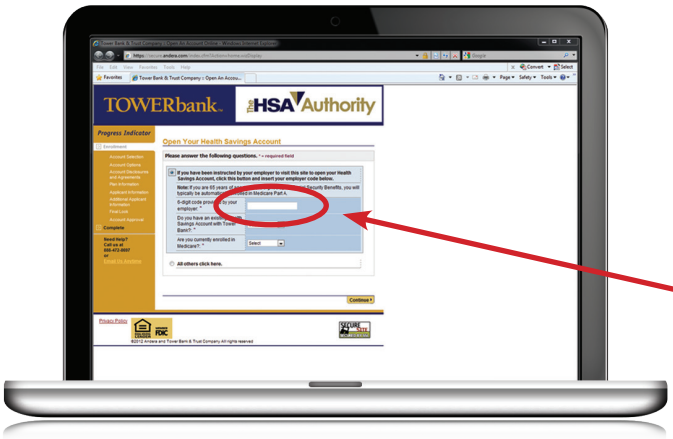
- Unexpired government issued ID for the account holder and for an authorized signer, if elected. This can be a driver's license, state-issued ID, passport, or military ID.
- The social security number and date of birth for your beneficiaries.
- The social security number and date of birth for the authorized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

Complete the following steps to open your account:

1. Go to **theHSAauthority.com** and click on the"Enroll Now" button which takes you to the enrollment program.

Note: If you already have an open HSA with The HSA Authority at Tower Bank, you do not need to complete the account opening process again.

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



State of Indiana

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'll be mailed separately and will arrive following the welcome letter.

To Access Your Account

Your Welcome Letter contains your new HSA number along with instructions for accessing Tower Bank's online banking site and telephone banking system. If you'd like assistance using these services, please call our Customer Care Center toll-free at 888.472.8697, option 1.

The HSA Authority™
Your HSA Partner

Website Features

Visit theHSAauthority.com for helpful tools!

HSA Calculators

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

Health Information Links

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

Educational Tutorial

Pre-recorded tutorial including information about what an HSA is and how it works, how a high-deductible health plan with an HSA is different from a traditional insurance plan, eligibility rules, HSAs and retirement, and how HSAs can save you money.

HSA Resources

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

Medtipster

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

Forms and Address Changes

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

Contact Us

Contact Customer Care at 888.472.8697, option 1, or send an email to info@theHSAauthority.com for more information.

HSA's at Tax Time

- You'll receive **Form 1099 SA** for your yearly distribution total and **Form 5498 SA** for your yearly contribution total. These figures are reported to the IRS and they require you to report them on IRS Form 8889 when filing your federal taxes. See IRS Publication 969 or consult your tax advisor for further information.
- You may make contributions to your HSA for the previous calendar year up to the tax filing deadline, which is normally April 15th. On your deposit, be sure to indicate that the contribution is for the previous calendar year to ensure correct processing.

Insurance Coverage Changes

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

What If...

You fill a prescription at the pharmacy and need to pay for your medication using funds from your HSA.

1. Pay using your HSA debit card.
2. Write a check from your HSA.

You're at the pharmacy and realize you don't have your HSA debit card or checks with you, or you don't have sufficient funds in your HSA account.

Pay for the purchase with personal funds and later pay yourself back from HSA by:

1. Writing a check to yourself.
2. Making an ATM withdrawal.
3. Purchase non-medical items with HSA debit card equal to the medical expense, save the receipts and make notes for your records.
4. Use Online Bill Payment to mail a check to yourself.
5. Call Customer Care to request a cashier's check.

You receive a medical bill in the mail and you do have funds available in your HSA for payment?

(Be sure your insurance company has already processed the bill and that you're only paying your portion of the negotiated rate.)

1. You can typically write your HSA debit card number on the provider invoice and have the payment debited from your account.
2. Initiate an individual or recurring payment through online bill payment.
3. Mail a check from your HSA.

You're faced with a medical emergency early in the year and you do not have enough in your HSA to cover your portion of the hospital bill?

1. Ask to set up a payment plan. As funds are deposited into your HSA you can make payments to the provider using your HSA debit card, online bill pay, or checks.
2. Pay 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 for paying the bill in full up-front. Most providers will agree to offer a 10%-30% discount.

You're 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 and save those receipts.
2. Mail the check to Tower Bank for deposit into your HSA, indicating that it's a reimbursement.

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

1. Ring up your groceries separately from your medical purchase and use your HSA debit card or checks for the prescription only.
2. Pay for everything with cash, personal credit card, personal debit card, or personal check, then repay yourself for the medical portion of the purchase later from your HSA funds.

Product Features

Enrollment Fee	**Free** online enrollment; $14.99 for paper enrollment
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 subject to change; refer to our website for information or call our Customer Care Center
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 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
Online Bill Pay	Pay bills online through online banking for nominal fee per transaction; refer to bank fee schedule
Debit Card	Up to two cards free for account owner and authorized signer
ATM Access	Free ATM withdrawals at any Tower Bank ATM; fees will apply for ATM withdrawals at non-Tower ATM's; refer to bank fee schedule
Check Fees	No per-check fees; see website for current printing fee per order of 50 checks
Certificate of Deposit Options	Available; call for current rates and terms; FDIC insured
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

Customer Care Center

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

Address: The HSA Authority; ATTN: Processing Center; PO Box 11454; Fort Wayne, IN 46858
Email: info@theHSAauthority.com
Phone: 888.472.8697, option 1, 8:00 am – 6:00 pm ET, Monday through Friday
Online Chat: Available through Online Banking, 8:00 am – 5:00 pm ET, Monday through Friday

Related service fees are subject to change; please refer to our website for current information. 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

Express Scripts prescription coverage

In 2014, state health plan members' Express Scripts benefits remain unchanged from 2013. As one of the largest pharmacy benefit managers, Express Scripts provides some of the best resources available in the market today.

Not only does Express Scripts process members' pharmacy claims, but they offer a number of other cost- and time-saving features. For instance, if you are serious about making the right choices for your health care benefits in 2014, log onto Express Scripts website (www.express-scripts.com) and review the claims that have been submitted for your 2013 prescriptions.

Then, take it a step further, and shop for the lowest price on your medications. Simply enter the name of your prescription and the website lists the price and any generics or other options for treatment of your particular condition. This helps you to make informed investments of your healthcare dollars.

Keep in mind that in addition to retail pharmacies, you can utilize Express Scripts' mail order pharmacy. They offer a 90-day supply on some medications. After you meet your deductible, you can purchase a 90-day supply for the cost of 60 days. That could provide you quite a savings. Armed with the costs of your medications, that information could help you better calculate your prescription costs for 2014.

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

To learn more about the state's retail and mail-order prescription drug programs through ESI and some of the cost- and time-saving features that provide value to our employees:

- Visit www.express-scripts.com
- Call 1-877-841-5241

Note: The ID card that you receive from Anthem includes information about Express Scripts (formerly Medco) and your identification number that the pharmacy uses. New cards are being issued so after January 1, 2014, Medco cards will be expired.

State of Indiana Rx Benefit Comparison
Summary of Benefits for 2014

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 (up to 30 day supply)	Mail order (up to 90 day supply)
Preventive (generics mandated by the Affordable Care Act)	$0 (not subject to the deductible)	$0 (not subject to the deductible)
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)	

*For more information on the preventive drugs covered 100% by our plan, call Express Scripts (formerly Medco) at 1-877-841-5241.

Additional benefits

Dental Coverage

The dental plan through Delta Dental provides 100 percent diagnostic and preventive coverage, as long as an in-network dentist is used.

Also covered 100 percent 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 check with Delta Dental before agreeing to the treatment.

Contact Delta Dental

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

By using an in-network dentist oral surgery, fillings and the repair of diseased, damaged or injured teeth is covered at 80 percent of the cost.

More information is available about dental coverage by logging on here: www.in.gov/spd/2859.htm.

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.

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 are 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
Dental Plan Highlights
STATE OF INDIANA – Group #9840

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.

Benefit Year - January 1 through December 31	**PPO Dentist**		**Premier Dentist**		**Nonparticipating Dentist**	
Covered Services -	Plan Pays	You Pay	Plan Pays	You Pay	Plan Pays	You Pay
Diagnostic & Preventive						
Diagnostic and Preventive Services - 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.	100%	0%	100%	0%	90%	10%
Basic Services						
Oral Surgery Services - Extractions and dental surgery	80%	20%	80%	20%	70%	30%
Endodontic Services - root canals	80%	20%	80%	20%	70%	30%
Periodontic Services - Used to treat diseases of the gums	80%	20%	80%	20%	70%	30%
Minor Restorative Services - 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%
Major Services						
Prosthodontic Services - Used to replace missing natural teeth (for example, bridges, implants and dentures).	60%	40%	60%	40%	50%	50%
Orthodontic Services						
Orthodontic Services (no age limit) - Used to correct malposed teeth (for example, braces).	60%	40%	60%	40%	50%	50%

Maximum Payment - $1,000 per person total per benefit year on Diagnostic & Preventive, Basic Services and Major Services. Delta Dental's payment for Orthodontic Services 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 Basic Services and Major Services. The deductible does not apply to Diagnostic & Preventive or Orthodontic Services.

Additional benefits

Vision Coverage

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 1-800-CONTACTS, LensCrafters®, Target Optical®, JCPenney® Optical, Sears Optical℠, 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
PEARLE VISION
OPTICAL
JCPenney jcp.com
Sears Optical
1 800 CONTACTS

Blue View Vision℠ Select
State of Indiana

Anthem

Vision Care Services	Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary	$10 Copay	Up to $35
Contact Lens Fit and Follow-up: (A contact lens fitting and two follow-up visits are available to you once a comprehensive eye exam has been completed.)		
Standard*	$40 Copay Paid-in-full fit and two follow up visits	Up to $35
Premium**	10% off retail	Up to $35
Frames	Up to $110 allowance	Up to $35
Standard Plastic Lenses:		
Single Vision	$25 Copay	Up to $25
Bifocal	$25 Copay	Up to $40
Trifocal	$25 Copay	Up to $55
Standard Polycarbonate (add-on the lens copay)	$20 Copay	N/A
Lens Option (paid by member and added to the base price of the lens):		
Tint	$15	N/A
UV Coating	$15	N/A
Standard Scratch-Resistant	$15	N/A
Standard Progressive (add-on to bifocal)	$65	N/A
Standard Anti-Reflective	$45	N/A
Other Add-ons	20% off retail	N/A
Contact Lenses (allowance covers materials only):		
Conventional Elective	$0 Copay; $105 allowance 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
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.

Additional benefits

Vision Coverage

BLUE VIEW VISION SELECT ADDITIONAL SAVINGS	MEMBER SAVINGS
Additional Pair of Complete Eyeglasses	40% discount off retail*
Contact Lenses - Conventional *(Discount applied to materials only)* Visit www.eyemedcontacts.com to order replacement contact lenses for shipment to your home at less than retail price.	15% off retail price
Eyewear Accessories Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases, etc.	20% off retail price

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

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

USING YOUR BLUE VIEW VISION SELECT PLAN
The Blue View Vision Select network is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

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

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

About your 2014 Vision benefit

Vision and health conditions, such as diabetes and high blood pressure, can be revealed and detected early through a comprehensive eye exam. Take care of your vision and overall health while saving on your eye care and eyewear needs.

The vision plan through Anthem Blue View Vision offers employees and their dependents a large network of ophthalmologists, optometrists, opticians, retail locations and discounts. Look for providers in the Select network at www.anthem.com.

More information about vision coverage can be found at: www.in.gov/spd/2860.htm.

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

To find a doctor in the Blue View Vision provider directory:

1. Visit www.anthem.com and select "Find a doctor" on the right.
2. You will automatically be under the medical section, so select Vision under "What are you looking for?"
3. You can then enter any information you would like to search for the provider (zip code, address, etc).
4. Under Section 5, you must enter the following below before clicking Search:
   - State: Indiana
   - Plan Type: Vision Plans
   - Plan Name: Blue View Vision Select

Additional benefits

Flexible Spending Accounts

A Flexible Spending Account (FSA) provides another opportunity for you to better control your health care dollars. By tucking away pre-tax dollars from your paycheck, you have an account that's dedicated for the reimbursement of qualified medical, vision and dental expenses.

All FSAs offered by the state have a use-it-or-lose-it rule. Money left at the end of the plan year is not rolled over or reimbursed, so plan carefully.

You must re-enroll in a FSA each year. If you decide that an FSA is right for you and your family, it is important to be conservative when allocating the yearly amount.

The state's FSA program is administered through Key Benefits Administrators. The administrative fee will remain at $2 biweekly.

Three types of FSAs: Medical Care, Limited Purpose and Dependent Care

Medical Care and Limited Purpose FSAs allow employees to use pre-tax dollars to cover health care costs for medical, dental, vision, hearing and other out-of-pocket expenses not paid by insurance.

For 2014, the maximum annual contribution for the Medical Care and Limited Purpose FSAs is $2,500.

A Limited Purpose FSA may only be used for dental, vision and preventive care expenses until the minimum deductible of a CDHP is met ($1,250 for single and $2,500 for family, per federal regulations). Once the minimum deductible is met, the Limited Purpose FSA can be used as a Medical Care FSA.

If you are enrolled in a CDHP/HSA, your FSA will automatically become a Limited Purpose FSA. You do not need to meet the minimum deductible to use the funds in your Limited Purpose FSA for dental and vision expenses. You can pay for dental and vision expenses from your Limited Purpose FSA at any point during the year.

About Dependent Care

Dependent Care FSAs are not front-loaded. Portions of your biweekly pay are 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 married and filing separate tax returns).

Dependent care expenses do not include medical expenses and therefore can be used even if you participate in a HSA.

You may be able to benefit from a Dependent Care FSA if you pay someone for your dependent who is uder age 13 or four your spouse or dependent who is not able to care for himself or herself.

For more information go to: www.in.gov/spd/2870.htm.

Additional benefits

Life Insurance

We are excited to introduce Minnesota Life Insurance Company as our new life insurance carrier for 2014. Your current life insurance elections will be carried over to Minnesota Life. You do not need to re-enroll. During this initial enrollment we are offering employees carrying Supplemental Life Insurance the opportunity to increase their coverage up to $20,000 in additional coverage without Evidence of Insurability. Employees with $15,000 in dependent life will be able to increase to $20,000 without Evidence of Insurability. Employees with any level of Child Only dependent life insurance will be able to increase their coverage up to $20,000. Additional options that require Evidence of Insurability will be available in 2014.

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.

Note: As of January 1, 2014 you are no longer required to individually enroll each eligible dependent in dependent life insurance. Your election of dependent life insurance will be considered an election to enroll all eligible dependents within the selected category.

Life insurance elections are limited to the guaranteed maximums. These limits do not require proof of good health, also called Evidence of Insurability (EOI).

Supplemental Life

- Current Supplemental Term Life participants can increase coverage by two levels ($20,000) up to $170,000 without providing EOI.

Spouse Life Only

- Employees with $15,000 in Spouse Term Life coverage, can increase to $20,000 without providing EOI.

Child Life Only

- All coverage is guaranteed. EOI is not required.

Spouse and Child Life

- Employees with $15,000 in Spouse and Child Term Life coverage can increase to $20,000 without providing EOI.

For more information on life insurance visit www.in.gov/spd/2868.htm.

Life Insurance Rates - 2014

Basic

Biweekly Employee Share	$0.0565/$1,000 of salary rounded up

Supplemental Life

Age	Biweekly rate/ $1,000 of coverage
0-29	$0.048
30-39	$0.048
40-44	$0.078
45-49	$0.126
50-54	$0.194
55-59	$0.311
60-64	$0.446
65 +	$0.718

Dependent Life

Coverage amount	Biweekly rate
Spouse 5k	$0.720
Spouse 10k	$1.440
Spouse 15k	$2.160
Spouse 20k	$2.880
Child(ren) 5k	$0.450
Child(ren) 10k	$0.900
Child(ren) 15k	$1.350
Child(ren) 20k	$1.800
Spouse & Child(ren) 5k	$1.000
Spouse & Child(ren) 10k	$2.000
Spouse & Child(ren) 15k	$3.000
Spouse & Child(ren) 20k	$4.000

Notices

Eligibility Requirement 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: A member of the opposite sex to whom you are legally married. IC 31-11-1-1(b) provides: A marriage between persons of the same gender is void in Indiana even if the marriage is lawful in the place where it is solemnized. Indiana does not recognize common law marriage entered into after Jan. 1, 1958. Employees are not allowed to claim dependents based on common law marriages.

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

Making changes after open enrollment

After noon (Indianapolis time) on Wednesday, Nov. 20, 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.

Dependent Eligibility

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

Disabled dependents under the age of 26 can be enrolled in any of your desired plans during the Open Enrollment period.

Once your dependent turns 26-years-old, you will have 120 days from the day of your disabled dependent's 26th birthday to submit the "Verification of Dependent Disability" form (which must be signed and completed by a physician) to the State Personnel Benefits Division. This form is available on State Personnel's website at www.in.gov/spd/openenrollment.

Please note: In order for a disabled dependent to continue coverage past 26 years of age, that dependent child must have been deemed disabled prior to age 19. If a dependent child was deemed disabled after age 19, they will not be eligible to continue coverage past age 26.

You must access PeopleSoft during open enrollment and edit your dependent information. Keep in mind, you will have to enroll your dependents on **each** plan (medical, dental, vision, dependent life) for which you desire coverage.

***Please review your dependents carefully. The state will be conducting an audit for all new dependents added for Open Enrollment 2014. This audit will occur in the first few months of the year. You will be required to submit documentation showing their eligibility. If you have any questions regarding dependent eligibility, please contact the Benefits Hotline.**

Notices

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 Express Scripts is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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)

The Children's Health Insurance Program Reauthorization Act of 2009 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 www.insurekidsnow.gov to find out how to apply. Please review the information posted on the Benefits website for more details.

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

As required by the Women's Health and Cancer Rights Act 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;
3. Prostheses; and
4. 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.

Notices

HIPAA Notice of Special Enrollment Rights

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

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your, or your dependents', coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your, or your dependents', determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact the Benefits Hotline at 317-232-1167 (within Indianapolis) or toll free 1-877-248-0007 (outside the 317 area code).

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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
Prescriptions Program Express Scripts	Customer Service: 1-877-841-5241	www.express-scripts.com
Flexible Spending Accounts Key Benefit Administrators, Inc. P. O. Box 55210 Indianapolis, IN 46205-0210	Customer Service: 1-800-558-5553	www.keyqualifiedplans.com
Life Insurance Minnesota Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098	Customer Service: 1-866-293-6047	www.LifeBenefits.com
Employee Assistance Program Anthem EAP	Customer Service: 1-800-223-7723	www.anthemeap.com
Anthem 24/7 NurseLine	1-888-279-5449	

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

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: A member of the opposite sex to whom you are legally married. IC 31-11-1-1(b) provides: A marriage between persons of the same gender is void in Indiana even if the marriage is lawful in the place where it is solemnized. Indiana does not recognize common law marriage entered into after Jan. 1, 1958. Employees are not allowed to claim dependents based on common law marriages.
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 (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.

Enrollment
Process by which an employee chooses the insurance plans/

(Continued on page 37)

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 disease or condition that is immediately possible. This

(Continued on page 38)

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 2014, open enrollment is Oct. 30 through noon Nov. 20 (EST). Changes you make during Open Enrollment take effect Jan. 1, 2014.

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.

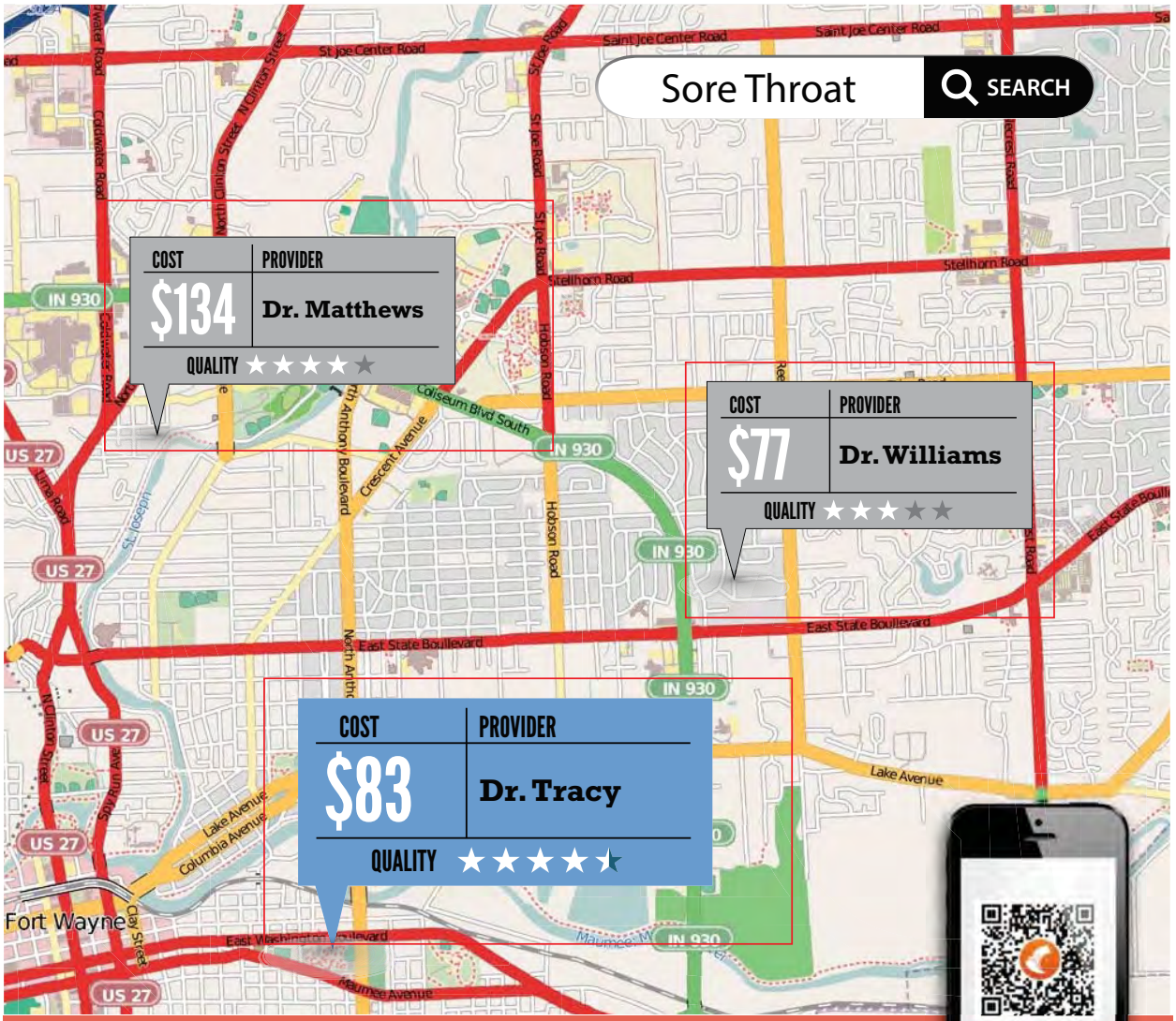
Termination of Coverage Date
First day coverage under the insurance plan ends.

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.

CASTLIGHT HEALTH

Take Charge of Your Health Care



BETTER CARE DOESN'T HAVE TO BE EXPENSIVE CARE.

Castlight's health care shopping tool is provided free of charge to all state employees and their adult family members enrolled in a State of Indiana medical plan.

REGISTER AND LEARN MORE AT mycastlight.com/stateofindiana

OR CALL 888-920-1264

Invest In Your Health

Healthy Lifestyles

A single step can put you on a better path to wellness

Take your Well-Being Assessment today, and start moving forward.

Taking your Healthy Lifestyles Well-Being Assessment (WBA) may be one of the best things you do for your health this year. Why? Besides getting an overview of your current health, the results of your assessment can also help you create a personalized well-being plan. With this plan, you can take action by making positive behavior changes and tracking your progress. You can also:

- Set a daily or weekly goal – such as walking 10,000 steps per day – and easily track to find out if the goal was met.
- Add a variety of custom trackers to keep tabs on your stress, weight, exercise, how much water you drink and more.
- Set reminders to track your activity.
- Share your activity on social networks such as Facebook, and track your progress on the go with the easy-to-use wellbeingGO app for your iPhone, iPod Touch or Android.
- Find simple, healthy recipes your whole family will love.
- Earn points that you can redeem for great prizes like fitness DVDs, kitchen gadgets and more.

Here's how to get started:

1. Go to **MyHealthyLifestyles.com** and select **Sign Up**.
2. After entering your information, select **Well-Being Assessment** to get started.
3. Congratulations! You now have the tools and resources that will help you reach your goals.

The site suggests up to three areas you can focus on, including exercise and fitness, weight management, healthy eating, quitting tobacco, stress management or medication management.

Choose your own path, with your well-being plan as a roadmap.

Get started by signing for Healthy Lifestyles and taking your WBA today at **MyHealthyLifestyles.com**

Anthem BlueCross BlueShield

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24/7 NurseLine

Always here for your employees – any time, any place
Health concerns don't take vacations or happen only when "the doctor is in." They happen at all hours, during vacations, even during business travel. Sometimes it isn't always clear whether a problem needs medical care. And if it does, choosing the right level of care can be confusing.

24/7 NurseLine gives your employees access to qualified registered nurses anytime. Our nurses help members by answering questions about their health concerns. Whether it's a question about allergies, earaches, types of preventive care or any other topic, answers and support are always there.

Choosing the right level of care can save members time and money, giving them access to the best possible care. The 24/7 NurseLine can help members decide if emergency or urgent care is more appropriate if their doctor isn't available. And 84% of our members agree that 24/7 NurseLine is a trusted resource.[1]

AudioHealth Library
Not everyone wants to talk about their health concerns with someone else. Some people just want to get more information on a health topic. That's why we provide the AudioHealth Library, with more than 300 helpful prerecorded health topics in English and Spanish. It's accessible by phone and, like the 24/7 NurseLine, it's always available.

24/7 NurseLine strives to:

- Help lower health care costs by providing members with health information to help them decide which level of care they may need. Members who use our 24/7 NurseLine are 50% less likely to go to the ER for non-emergency cases.[2]
- Help increase members' satisfaction with their health care plan. Of members surveyed, 85% would recommend 24/7 NurseLine to others.[1]

Anthem BlueCross BlueShield

1 2010 WellPoint Member Satisfaction Survey
2 Anthem Health and Wellness Solutions Internal data, Jan. – Dec. 2008

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EANSH1283A Rev. 8/11 F0011166

If you have a serious injury or health issue,

We're here when you need us most

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

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

For instance, depending on your needs, a case management nurse might help you:

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

Anthem BlueCross BlueShield

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If you choose to use this free service, you'll work one-on-one with your personal case management nurse.

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

1. **Get started**. In most cases, someone from this program contacts you directly. You can also call the customer service number on your member ID card or the health benefits team where you work. Ask to get in touch with the case management team. Your nurse will call you and get to know you. You'll talk about your current health situation and how it affects you. But you'll also talk about your health goals — and how your nurse can help you reach them.
2. **Stay in touch**. Your nurse will call you regularly to see how you're doing and to offer support with any health issues. This is important because your needs may change over time. You'll also have your nurse's direct phone number, so you can call if any questions or problems come up.
3. **Get better**. If you don't think you need help anymore, just let your nurse know. You can stop participating at any time.

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

For information about other member programs available to you, visit our website at anthem.com.

Case Management's high satisfaction scores

Nearly 9 out of 10 members who use this service say they're "very satisfied" and would recommend the program to another member.*

*2008 member satisfaction study.

Anthem BlueCross BlueShield

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ConditionCare

Anthem BlueCross BlueShield

The right level of individualized interventions at the right time.

Today, most physicians and clinical staffs have limited "face time" with their patients. Some individuals are in denial about their chronic illness, and others can feel overwhelmed by information. All can lead to poor management of the chronic condition and poor overall health.

The **ConditionCare** program serves as an excellent adjunct to physician care. Nurse Coaches and added support from our team of dietitians, social workers, pharmacists, health educators and other health professionals will help members understand their condition, their doctor's orders and how to become a better self-manager of their condition.

Our total health solution works with the physician's plan of care to help the member make healthier behavior choices. The goal of the program is to achieve optimal wellness with optimal cost efficiency by:

- *Helping the physician/member relationship and the physician's plan of care.*
- *Helping reduce complications by using evidence-based nursing practice guidelines and participant empowerment strategies.*
- *Screening for depression and engaging behavioral health professionals as needed.*
- *Evaluating clinical, personal and economic outcomes on a consistent basis to help improve overall health.*

Health Information Profile

Starting with the member's own self-identified long-term goal, we collaboratively work with the participant to create a Health Chart, a personalized care "blueprint" that organizes specific goals and action steps to help achieve better health.

These goals are based on an individual's current health status and behaviors and the physician's prescribed treatment plan. A Nurse Coach helps the member by coordinating care, encouraging adherence to the plan, providing education and coaching. Additionally, a Nurse Coach involves other licensed Anthem health care professionals when necessary, including pharmacists, dietitians, social workers, health educators and physicians.

ConditionCare helps participants manage the following conditions:

- *Asthma (pediatric & adult)*
- *Chronic obstructive pulmonary disease (COPD)*
- *Coronary artery disease (CAD)*
- *Diabetes (pediatric & adult; types 1 & 2)*
- *Heart failure (HF)*

ConditionCare reports an ROI of at least $2:$1 or better. That means for every dollar invested, our customers realize $2 or more in savings.

Source: Internal Health and Wellness Solutions data study and Actuarial validation, 2009.

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EANSH1285A Rev. 6/11 F0014192

Getting care when you need it now

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

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

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

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

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

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

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

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

Before you go

Call the office or clinic and ask:

- What are your hours?
- Do you have the services I need?
- Will this be covered by my plan?

Average cost

$800*	$10 – $80*
ER visit	Retail health clinic Doctor's office visit Urgent care center

*Deductibles and coinsurance apply.

Emergency room rule of thumb

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

Want more information on ER alternatives?

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

1 Centers for Disease Control and Prevention, National Hospital Ambulatory Care Survey, August 2008.

Anthem®

Health. **Join In.**℠

25345INMENABS 10/11

If you need care right away, the ER can be crowded and may cost more. If it's not a medical emergency, try the other choices.

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

Deciding where to go when you need care right away

	Who usually provides care	Sprains, strains	Animal bites	X-rays	Stitches	Mild asthma	Minor headaches	Back pain	Nausea, vomiting, diarrhea	Minor allergic reactions	Coughs, sore throat	Bumps, cuts, scrapes	Rashes, minor burns	Minor fevers, colds	Ear or sinus pain	Burning with urination	Eye swelling, irritation, redness or pain	Vaccinations	Average Cost
Retail Health clinic	Physician assistant or nurse practitioner									•	•	•	•	•	•	•	•	•	$10 – $40*
Walk-in doctor's office	Family practice doctor					•	•	•	•	•	•	•	•	•	•	•	•	•	$10 – $40*
Urgent Care Center	Internal medicine, family practice, pediatric and ER doctors	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	$40 – $80*
Emergency Room	Some examples of medical emergencies are: • Any life-threatening or disabling condition • Sudden or unexplained loss of consciousness • Chest pain; numbness in the face, arm or leg; difficulty speaking • Severe shortness of breath • High fever with stiff neck, mental confusion or difficulty breathing • Coughing up or vomiting blood • Cut or wound that won't stop bleeding • Major injuries • Possible broken bones																		$800*

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

*Deductibles and coinsurance apply.

Let a nurse help you decide

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

Wondering where to go?

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

At Anthem Blue Cross and Blue Shield, we're always looking for new ways to save you time and money, and help you get more value from your health care.

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Sometimes it's good to talk things out.

Whatever's troubling you, you don't have to face it alone.

Maybe you're a few months behind on bills and want to get back on track. Maybe you're new to town and looking for a daycare center. Maybe you have a big project at work and are feeling a lot of stress. Whatever your concern, big or small, a call to your Employee Assistance Program (EAP) can help you through it.

Just call 800-223-7723 or visit anthemEAP.com and enter State of Indiana.

You'll be connected in an instant. We're here 24/7, every hour and every day, to help you.

We also have online help, so you can browse resources online – at the time and place that are right for you. Some of the topics include:

- Child and elder care
- Tobacco cessation
- Grief and loss
- Depression/mental health concerns
- Family health
- Home improvement
- Addiction and recovery
- Identity theft
- Legal assistance
- Workplace safety

*In accordance with federal and state law, and professional ethical standards

Your privacy matters

Remember, your privacy is important to us. No one will know you've called EAP unless you give them permission in writing.*

Invest In Your Health

Anthem BlueCross BlueShield

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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.

Anthem®
Health. Join In.℠

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Anthem

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® Registered Marks Blue Cross and Blue Shield Association.

THIS IS NOT A BILL

CHECK NUMBER:	N/A
1 PATIENT:	PATIENT, IMA
PATIENT ACCOUNT #:	
INSURED ID: 2	ABC123M45678
3 PROVIDER:	JOHN SAMPLE MD
CLAIM #: 4	SPECIAL00000
PROVIDER PARTICIPATION STATUS:	OUT OF NETWORK
EOB DATE:	09/19/2006
AMOUNT PROVIDER MAY BILL YOU, IF NOT ALREADY PAID 5	100.00

6 YOUR BENEFIT SNAPSHOT*

BENEFIT YEAR 2006	BENEFIT AMOUNT	AMOUNT MET-YEAR TO DATE	REMAINING BALANCE
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 KLJYLKYUQ KY 12345

DATE(S) OF SERVICE	CODES	TYPE OF SERVICE	CHARGE	ALLOWABLE AMOUNT	PROVIDER RESPONSIBLITY	REASON CODE(S)	DEDUCTIBLE	COPAY/ COINSURANCE	ADDITIONAL MEMBER RESPONSIBILITY	REASON CODE(S)	AMOUNT PAID TO PROVIDER
7		8	9		10				11		12
02/02/2006-02/02/2006	99245	MEDICAL CARE	100.00	100.00	0.00		100.00	0.00	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 EXPLAINATION 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 PLANSí 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.

SAMPLE

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.*

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Anthem BlueCross BlueShield

The best organizational tool since colored file folders.

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

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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".

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Take care of yourself

Remember to get preventive care

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

Our health plans and policies cover 100% of the services listed in this preventive care flier.[1] When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses.

For example, say your doctor suggests you have a colonoscopy because of your age. That's preventive care. On the other hand, say your doctor suggests a colonoscopy to see what's causing your symptoms. That's diagnostic care and you may need to pay part of the cost.

Here's an overview of the types of preventive services we cover. See your benefits summary to learn more.

Child preventive care (birth through 18 years)

Preventive care physical exams are covered. So are the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Ask your doctor what's right for you.

Preventive physical exams

Screening tests (depending on your age) may include

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cholesterol and lipid level
- Depression
- Development and behavior
- Hearing
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- Lead testing
- Newborn
- Obesity, including counseling
- Oral (dental health)
- Sexually transmitted infections
- Vision[2]

Immunizations

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chicken pox)

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Adult preventive care (19 years and older)

Preventive care physical exams are covered. So are the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Ask your doctor what's right for you.

Preventive physical exams

Screening tests and services (depending on your age) may include

- Aortic aneurysm screening (men who have smoked)
- Blood pressure
- Bone density test to screen for osteoporosis
- Breast cancer, including exam and mammogram
- **Breastfeeding support, supplies and counseling (female)[3, 4]**
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and CT colonography (as appropriate)
- **Contraceptive (birth control) counseling and FDA-approved birth control methods that need a prescription (female)[4, 5]**
- Depression
- Eye chart test for vision[2]
- Hearing
- Height, weight and BMI
- HIV screening
- **HPV (female)[4]**
- Intervention services (includes counseling and education):
  - Behavioral counseling to promote a healthy diet
  - Counseling related to aspirin use for the prevention of cardiovascular disease (does not include coverage for aspirin)
  - Genetic counseling for women with a family history of breast or ovarian cancer
  - Primary care intervention to promote breastfeeding
  - Screening and behavioral counseling related to alcohol misuse
  - Screening and behavioral counseling related to tobacco use
  - Screening and counseling for interpersonal and domestic violence
  - Screening and counseling for obesity
- Pelvic exam and Pap test, including screening for cervical cancer
- Prostate cancer, including digital rectal exam and PSA test
- Screenings during pregnancy (including, but not limited to, **gestational diabetes[4]**, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV)
- Sexually transmitted infections

Immunizations

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A
- Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- MMR
- Pneumococcal (pneumonia)
- Varicella (chicken pox)
- Zoster (shingles)

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

1 Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.
2 Some plans and policies cover additional vision services. Please see your contract or Certificate of Coverage for details.
3 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.
4 This benefit is covered under health care reform's women's preventive services. For group plan members, these services are covered with policy years beginning after August 1, 2012. For members with individual coverage, these benefits are effective for new members on or after August 1, 2012 and for current members on January 1, 2013. This benefit also applies to those younger than 19.
5 To get 100% coverage for a covered prescription for birth control, it must be a generic drug or a brand-name drug that doesn't have a generic equivalent. Also, you'll need to fill the prescription at an in-network pharmacy. A cost-share may apply for other prescription contraceptives, based on your drug benefits.

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Anthem BlueCross BlueShield

Get healthy. Stay healthy.

The power of prevention

Why a wellness exam is worth your time

Like it or not, your body changes as you get older. Wellness exams give you a chance to talk with your doctor about these changes. Plus these exams can help you build a relationship with the doctor over time. This could help you get better care if problems come up later.[1]

You may wonder if "wellness exam" is just a new term for "annual physical." It isn't. There are two key differences:

- They can happen any time. The timing depends on your age and your health.
- They focus on more than just problems. They also cover things you can do to live a healthier, more active life. For example, they may talk about watching your weight, getting a flu shot or getting your eyes checked. But if you have signs of a health problem, be sure to tell your doctor.

What to expect

Most wellness exams start with a talk about your health history and any problems. After that, most doctors will spend time on things like:[2]

- Any medicines you take.
- How you eat — and how you could eat better.
- How physically active you are — and whether you should be more active.
- Any stress in your life or signs of depression.
- Drinking, smoking and recreational drug use.
- Safety measures like wearing your seat belt and shielding yourself from the sun.
- Your sexual habits and any risks they pose.
- Tests and vaccines you may need.

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The U.S. Preventive Services Task Force puts out these general recommendations.[3, 4] Your doctor may suggest other tests or more frequent tests. Alot depends on your risk factors. These are things that make you more likely to get an illness, like your family history or age.

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 (younger if you smoke, have diabetes, have high blood pressure or have a family history of heart disease)
Skin exam	Self-exams at least once a year; talk to your doctor about screening (especially if you are 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 reasons you may need to be tested

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	Routine screening starting at age 65 (age 60 for women with risk factors like a small frame or weight under 155 pounds)
Chlamydia	Routine screening for all sexually active women age 25 and younger; talk to your doctor about tests for other illnesses that spread through sex

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 the ages of 65 to 75 if you have ever smoked

Making the most out of your medical exam

Try to see the doctor early in the day. He or she may not be as rushed then. Also think about bringing a family member or friend with you. Your friend can help you take notes, voice your concerns and ask questions.

Doctor visits can be very short, so it's a good idea to come prepared. Before your visit, write down details like:[2]

- Your health history and your family's health history. This is even more important if anything has changed since your last visit.
- All the medicines you take. Note how much and how often. Be sure to include vitamins and over-the-counter drugs.
- Any concerns you have about your health.
- Any new symptoms you have.

Your doctor should be ready for your visit, too. He or she should know who you are and what you've talked about in the past. All it takes is a quick check of your chart before your visit. You deserve this type of personal care. And it's vital to building a long-term relationship with your doctor.

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

Anthem BlueCross BlueShield

Certain factual or statistical information was derived from the following sources:

[1] Centers for Disease Control and Prevention, "Regular Check-ups are Important," cdc.gov, updated April 2011, accessed December 2011.

[2] Centers for Disease Control and Prevention, "Check-Up Checklist: Things to Do Before Your Next Check-Up," cdc.gov, updated January 2010, accessed December 2011.

[3] Agency for Healthcare Research and Quality, "Women: Stay Healthy at Any Age," ahrq.gov, updated September 2010, accessed December 2011.

[4] Agency for Healthcare Research and Quality, "Men: Stay Healthy at Any Age," ahrq.gov, updated September 2010, accessed December 2011.

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