The Torch

The official newsletter for Indiana state employees

Open Enrollment Edition

Enroll online starting October 28

This special edition is dedicated to 2021 Open Enrollment. Please review all the enclosed information concerning your health care coverage. During this period, you can choose to make additions or changes to your benefit selections.

All Open Enrollment communications, including carrier information, rates and plan summaries, are posted on the Open Enrollment 2021 website: www.in.gov/spd/openenrollment.

2021 Benefits
Open Enrollment

Oct. 28 - Nov. 18

Deadline is Wednesday, Nov. 18 by noon EST

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

Eligibility for the state's benefit plans

There are no pre-existing condition limitations for any of the state's plans. All active, full-time employees and elected or appointed officials are eligible to participate.

For the purpose of benefits eligibility, full-time employees are defined as active employees whose regular work schedule is at least 30 hours per week.

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

Looking for plan rates?

View the 2021 plan rates > Download the complete rate chart >

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The Torch is published monthly by the Indiana State Personnel Department and is available online at in.gov/spd/2540.htm.

Got a story?

Submit your story ideas to: spdcommunications@spd.in.gov

Social media

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Checklist

The 2021 Open Enrollment checklist

Is your current plan still the right plan for you? Now is the perfect time to review all of the options, take a look at your family's current health and finances, and actively identify the plan option(s) that best meets your needs.

To make the election process easier, a number of resources are available to help you estimate your 2021 expenses, compare plans and become a more informed consumer. Use this checklist to help guide you through the steps to a successful Open Enrollment:

- ☑ Educate yourself about changes occurring January 1, 2021.
- ☐ Access your HR PeopleSoft account.
- ☐ Confirm or update personal information, including your home and/or mailing address, e-mail address, phone number and ethnic group.
- ☐ If you wish to drop your insurance coverage you need to select "waive."
- ☐ If you are eligible for the 2021 Wellness Premium Discount, your premium will automatically be reduced on which ever medical plan you select.
- ☐ Review your eligible dependents and beneficiaries.
  - You need to enroll all eligible dependents in each benefit plan you choose.
  - Make sure you remove ineligible dependents from all of your benefit plans and report their eligibility change to the Benefits Hotline.
  - Update personal information for each dependent and/or beneficiary (information must match what is on their social security card).
  - Add your dependent's social security numbers.
  - For dependent/beneficiary name changes and Social Security corrections, please contact the Benefits Hotline.
- ☐ Check your current elections or make new elections. It is important that you review the dependents enrolled on each of your plans.
- ☐ If you have a Health Savings Account (HSA), you need to enter your annual contribution amount.
- ☐ If you have a Flexible Spending Account (FSA), you need to re-elect or re-state your annual contribution amount.
- ☐ If you have a Commuter Reimbursement Account, your contribution will continue for 2021, unless you waive the coverage.
- ☐ Review the Non-Tobacco Use Agreement and accept or decline the agreement for 2021.
- ☐ Be sure to print an Election Summary after you have submitted your elections.
- ☐ If you have any questions regarding your benefits, please contact the Benefits Hotline at 317-232- 1167 or toll-free at 877-248-0007 (if outside of the Indianapolis area).

Opportunities are available to learn more about your 2021 benefit options

Informational Sessions via Microsoft Teams

Each one-hour informational session will be hosted by a representative of the Indiana State Personnel Department's Benefits Division. The session will be an overview of your 2021 Open Enrollment options. Questions are welcomed.

Vendor Fairs via Microsoft Teams

The state is also offering virtual Vendor Fairs. Through the event, you have access to speak to a vendor representative directly.

Select here for more information about the Informational Sessions and Vendor Fairs.

When do my 2021 Open Enrollment changes take effect?

Medical, dental and vision changes/ enrollments:

- Effective: January 1, 2021
- First Deduction: December 23, 2020 (5 days of 2020 rates; 9 days of 2021 rates)

Flexible Spending Account (FSA), Commuter Benefit Reimbursement Account, and Health Savings Account (HSA) changes/enrollments:

- Effective: January 1, 2021
- First Deduction: January 6, 2021

Life insurance changes/enrollments:

- Effective: January 10, 2021
- First Deduction: January 6, 2021

For direct bill agency employees, your benefits will be effective January 1, 2021. For deduction information, please see your agency's Payroll Department.

Medical Plan Options

Medical Coverage – No Changes to Premiums or Plans

Did you hear the great news? The medical premiums and plans will remain the same for 2021! Like this year, the state will continue to offer three statewide medical plans for 2021: Consumer-Driven Health Plan 1 (CDHP1), Consumer-Driven Health Plan 2 (CDHP2) and Traditional Plan. All three available plans are in the National PPO (BlueCard PPO) network with Anthem and have a prescription drug plan through CVS Caremark.

Each plan has differences in premium costs, deductibles and out-of-pocket maximums. Below is an overview of each option.

	CDHP 1	CDHP 2	Traditional Plan
Single	$2,500	$1,750	$1,000
Family	$5,000	$3,500	$2,000
Out-of-Pocket Maximum*			
Single	$4,000	$3,000	$2,500
Family	$8,000	$6,000	$5,000
Co-Insurance			
In-Network	20%	20%	20%
Out-of-Network	40%	40%	40%

With an HSA	Single			Family		
	CDHP 1	CDHP 2	Traditional	CDHP 1	CDHP 2	Traditional
Annual Employee Premium	$879.84	$1,219.40	$2,584.40	$2,698.80	$3,940.04	$8,830.64
Maximum Out-of-Pocket Cost	$4,000	$3,000	$2,500	$8,000	$6,000	$5,000
State Paid HSA Contribution	($1,124.76)	($787.80)	N/A	($2,249.52)	($1,575.60)	N/A
Total Exposure	**$3,755.08**	**$3,431.60**	**$5,084.40**	**$8,449.28**	**$8,364.44**	**$13,830.64**

Without an HSA	Single			Family		
	CDHP 1	CDHP 2	Traditional	CDHP 1	CDHP 2	Traditional
Annual Employee Premium	$879.84	$1,219.40	$2,584.40	$2,698.80	$3,940.04	$8,830.64
Maximum Out-of-Pocket Cost	$4,000	$3,000	$2,500	$8,000	$6,000	$5,000
Total Exposure	**$4,879.84**	**$4,219.40**	**$5,084.40**	**$10,698.80**	**$9,940.04**	**$13,830.64**

Wellness Incentive Rates

With an HSA	Single			Family		
	CDHP 1	CDHP 2	Traditional	CDHP 1	CDHP 2	Traditional
Annual Employee Premium	$505.44	$845.00	$2,210.00	$1,575.60	$2,816.84	$7,707.44
Maximum Out-of-Pocket Cost	$4,000	$3,000	$2,500	$8,000	$6,000	$5,000
State Paid HSA Contribution	($1124.76)	($787.80)	N/A	($2249.52)	($1575.60)	N/A
Total Exposure	**$3,380.68**	**$3,057.20**	**$4,710.00**	**$7,326.08**	**$7,241.24**	**$12,707.44**

Without an HSA	Single			Family		
	CDHP 1	CDHP 2	Traditional	CDHP 1	CDHP 2	Traditional
Annual Employee Premium	$505.44	$845.00	$2,210.00	$1,575.60	$2,816.84	$7,707.44
Maximum Out-of-Pocket Cost	$4,000	$3,000	$2,500	$8,000	$6,000	$5,000
Total Exposure	**$4,505.44**	**$3,845.00**	**$4,710.00**	**$9,575.60**	**$8,816.84**	**$12,707.44**

R/x Coverage

Prescription Coverage

Similar to the medical plans, the prescription plan is remaining the same for 2021. As in the past, all three of the health plans will have prescription coverage through CVS Caremark. Each plan has the same copay/coinsurance amounts.

As a reminder, there is no requirement for an employee to switch to a CVS pharmacy. However, as an added benefit, 90 day supplies are offered both through mail service and CVS pharmacies. For a full list of in-network pharmacies, please visit www.caremark.com.

Through CVS Caremark, point-of-sale (POS) rebates will continue to be given to members. CVS Caremark negotiates with the drug companies to establish rebates for certain drugs. For example, a drug may have a list price of $250 with a rebate of $100. With the point-of-sale rebates, an employee will only be responsible for paying $150 at the time they pick up their prescription. In this example, the employee would save $100. Not only does POS rebates save employees money, they also make prescription purchases more transparent.

The easiest way to manage your prescriptions is through CVS Caremark's website or mobile app. Within both platforms, you may review your mail order prescription, check drug costs and coverage, find a network pharmacy and keep track of your prescription spending. You may also transfer a current prescription or submit a new one by simply submitting a picture of the prescription label or written prescription. For additional ease, you can even enroll in automated refills. To get started, all you need to do is register at Caremark.com or download the CVS Caremark mobile app.

Below is a quick look at the 2021 prescription coverage.

Prescription Drug	CDHP 1		CDHP 2		Traditional	
	CVS Caremark Retail Pharmacy Network (up to 30 days)	CVS Caremark Mail service Pharmacy or CVS Pharmacy (up to 90 days)	CVS Caremark Retail Pharmacy Network (up to 30 days)	CVS Caremark Mail service Pharmacy or CVS Pharmacy (up to 90 days)	CVS Caremark Retail Pharmacy Network (up to 30 days)	CVS Caremark Mail service Pharmacy or CVS Pharmacy (up to 90 days)
Preventive (ACA mandated)	$0 no deductible	$0 no deductible	$0 no deductible	$0 no deductible	$0 no deductible	$0 no deductible
Generic Medicines	$10 co-pay	$20 co-pay	$10 co-pay	$20 co-pay	$10 co-pay	$20 co-pay
Preferred Brand-Name Medicines	20% Min $30 Max $50	20% Min $60 Max $100	20% Min $30 Max $50	20% Min $60 Max $100	20% Min $30 Max $50	20% Min $60 Max $100
Non-Preferred Brand-Name Medicines	40% Min $50 Max $70	40% Min $100 Max $140	40% Min $50 Max $70	40% Min $100 Max $140	40% Min $50 Max $70	40% Min $100 Max $140
Specialty Medicines	40% Min $75, Max $150 (30 day supply)		40% Min $75, Max $150 (30 day supply)		40% Min $75, Max $150 (30 day supply)	

Anthem programs

Anthem offers support to help you achieve health goals

The state is committed to providing health plan members with helpful tools in order to achieve a more active and healthy population. All members enrolled in an Anthem plan receive special services in conjunction with the Anthem Health and Wellness Programs.

Anthem Health and Wellness Programs provide you with support to help you achieve your health goals. Through Anthem's online tool, you have access to resource materials to learn more about health topics and manage any ongoing health issues such as Diabetes, COPD, Cancer, Pregnancy, Tobacco Use and Weight Management to name a few. To start using the online tools, please go to www.anthem.com to log in to your account, place your cursor on the "My Health Dashboard" tab on the top of the page, and select programs.

In addition to the online tools, representatives from Anthem may contact you directly as part of one of the Health and Wellness programs. These programs include:

Case Management: Licensed health care professionals work with you and your treating providers as needed to develop a Care Management plan to help meet your needs. Case Management is designed to help members optimize their health care benefits.

ConditionCare: With the guidance of a dedicated nurse team and health professionals you will gain a better understanding of your health, receive help in following your doctor care plan, and learn how to better manage your health.

Future Moms: Provides moms-to-be with telephone access to nurses to discuss pregnancy-related concerns. This program provides the education and tools to help track the pregnancy week-by-week and prepare for the baby

For more information about these programs please contact Anthem toll-free at 877-814-9709.

Anthem programs

Anthem's 24 hour NurseLine

For those times you are not sure if you need to seek medical care or what level of care is needed, Anthem's NurseLine is available for you. The NurseLine provides anytime, toll-free access to nurses for answers to general health questions and guidance with health concerns. A nurse can help you understand your symptoms or explain medical treatments. Every caller receives credible, reliable information from a registered nurse.

With the help of NurseLine you can lower your health care costs by finding the appropriate level of care that you may need. Members who use NurseLine are 50% less likely to go to the ER for non-emergency cases. If non-emergency care is received in the ER when a more appropriate setting is available, that claim may be reviewed by a medical director using the prudent layperson standard and potentially denied. However, if you are advised by the NurseLine to seek treatment at the ER and it is later determined that the visit was for a non-emergent visit, the plan will cover the visit.

In addition, the NurseLine can also be used to learn more about specific health topics. More than 300 health topics have been prerecorded and are available in both English and Spanish. These recording are available 24/7 by phone.

To access NurseLine, please call 800-337-4770.

Feeling Sick?

The **Anthem NurseLine** is available 24/7 to help answer your questions.

If you are not feeling well call the line and a nurse will go over your symptoms, and walk you through what you need to do next.

Get Peace of Mind 24/7.

Anthem NurseLine: (800) 337 - 4770

Indiana State Personnel Department

Anthem BlueCross BlueShield

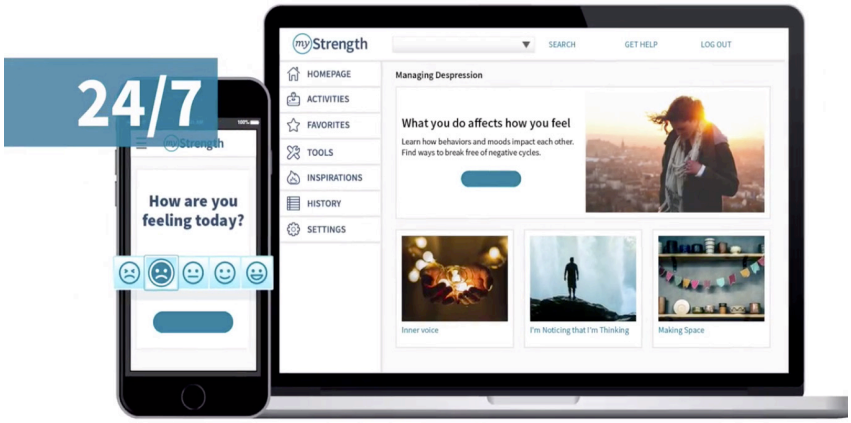
Anthem programs

myStrength: Online emotional wellness program

Through myStrength, you have free access to a unique, online emotional wellness program brought to you by Anthem.
Like a virtual gym for the mind, myStrength provides personalized and proven online and mobile resources to promote ongoing emotional well-being.

If you or someone in your family is struggling with depression, anxiety, overuse of drugs or alcohol, chronic pain, difficulty sleeping, or simply trying to manage everyday stress, help is available 24/7 from the comfort and privacy of your own home. MyStrength contains stress management tools, inspirational videos, articles, and quotes, as well as step-by-step eLearning modules to help you feel better and stay better.

To access myStrength today, log onto www.anthem.com. Once on the homepage, hover over the "My Health Dashboard" tab on the top of the page and select "Programs" from the drop-down menu. Scroll down to the myStrength tile and select the "Learn more" link. On the next page, select the "Sign up" link.



Anthem programs

OnDuo – Support for Your Type 2 Diabetes

The State of Indiana is excited to announce OnDuo, a new health benefit offered by Anthem as part of the state's medical plans. OnDuo is a virtual care program with the goal of helping those living with type 2 diabetes manage their condition. Through the program, participants will receive a connected glucometer, access to health coaches who specialize in diabetes, and the ability to meet virtually with endocrinologists to manage medicines. In addition, all participants will have access to an app to track blood sugar, food, and activity.
If you are interested in learning more or signing up, please visit https://onduo.com/stateofin/. Please note, all services are subject to your medical plan's deductible and coinsurance.

Last chance to earn e-gift cards!

It's almost too late!

It's fast and easy, but you'll need to be quick to earn this reward! Take a quick health assessment, earn a $50 e-gift card!

Log in to your ActiveHealth portal today and complete your health assessment. It only takes about 10 minutes and will give you a window into your wellness that can help you make the changes you need, discover resources for help, and feel better about feeling better!

You'll get an easy-to-understand health report that works as a great tool to help you set your own wellness goals, and if you decide to participate in health coaching, this report gives the health coach an excellent picture of where you are today on your wellness journey.

But you'll need to act fast! The deadline to complete your health assessment and receive your $50 e-gift card is Nov. 30! Your gift card is available immediately to be redeemed in your ActiveHealth portal. All you have to do is select "submit."

Don't forget: All e-gift cards must be redeemed by Dec. 31.

For more information about how to make the most of the many wellness resources available to you, visit InvestInYourHealthIndiana.com.

onduo

Anthem Programs

Customer Service redefined

Anthem Health Guide

Did you know that when you call Anthem customer service you will be connected to an Anthem Health Guide? Health Guides can be reached by phone, mobile app, email or even online chat via mobile device or computer. Health Guides work closely with health care professionals, like nurses, health coaches and social workers, to provide personalized and consultative support. A Health Guide can help you:

- Connect with the right benefits and programs for your health care needs including any of the Condition Care programs.
- Stay on top of your follow-up and preventive care with reminders and appointment-scheduling support.
- Compare costs for health care services and find in-network doctors.
- Answer questions about your claims and covered services.

Sydney Health

Another great tool is the Sydney Health app. Sydney Health is your own personal health assistant and benefits guide all rolled into one. To start simply download the app.

Log in using your Anthem User Name and Password from their web portal or register as a new user. With the Sydney app you can:

- Find care and check costs
- View claims
- View and use digital ID cards
- See all of your benefits including your deductible, co-insurance and out of pocket maximum
- Use the interactive chat feature to get answers quickly
- Sync with your fitness tracker
- Check My Family Health Records (myFHR)

Your Anthem Health Guide is here!

Anthem

Anthem Programs

Employee Assistance Program (EAP) benefits offer eight free face-to-face counseling sessions and more

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

Through EAP, you and your household have access to **eight face-to-face counseling sessions**, per issue with a licensed therapist. Access to this benefit is as easy as picking up the phone and calling 800-223-7723. When you call, you want to select option one, State of Indiana Employee Assistance Program, from the prompt menu. Once you are connected with an EAP representative, ask them about therapy visits. The representative is trained to assist you in finding a therapist that fits your needs and guide you through the process of scheduling your first appointment. For your convenience, appointments can even be scheduled within LiveHealth Online, face to face conversations with a doctor or therapist using a computer or mobile device. If you are interested in this option, please let the representative know.

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

- **Assistance with legal and financial concerns,** including a 30-minute initial consultation, per issue, with a qualified attorney or financial advisor.
- **Dependent care referrals.** Locate child and eldercare providers using online tools or calling your EAP directly.
- **Convenience services**. Obtain resources and information on pet sitters, educational choices for you or your children, summer camp programs and much more.
- **Website –** www.anthemEAP.com Contains a comprehensive level of resource articles, self-assessments, audio and video material covering emotional well-being, health and wellness, the workplace, and life issues such as childcare, eldercare, adoption and education.
- **Smoking cessation**. Speak with a wellness coach to set achievable milestones to quit tobacco. Additional support can be found through QuitNet, a free online program that will assist you in your tobacco cessation efforts with peer support from individuals in every stage of the quitting process along with lots of tips to keep you moving forward.
- **ID recovery and credit monitoring**. Assess your risk level and identify steps to resolve potential identity theft. Your EAP can help you complete any necessary paperwork, report to consumer credit agencies for you, and negotiate with creditors to repair your debt history.
- **Member center**. Includes access to a listing of EAP providers in your preferred area and routine counseling referral service.

To access Anthem's EAP online resources, visit www.anthemEAP.com. Once on their homepage, select the "Log in" button. On the next page enter your company code, "State of Indiana". Once you hit the "Log In" button, all of these services are open to you. There is free 24-hour, 7 days per week phone access at 800-223-7723 for immediate support.

Anthem Programs

Have you tried LiveHealth Online?

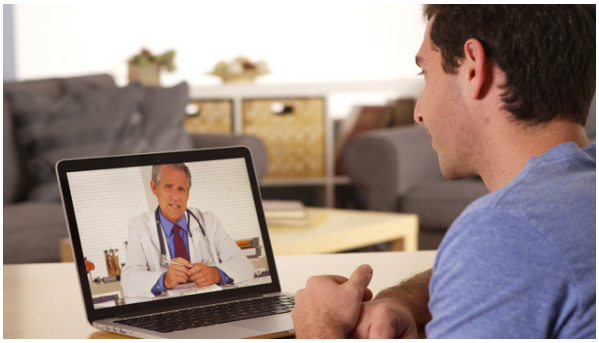
LiveHealth® ONLINE

Through LiveHealth Online, you have access to in-network, board-certified doctors 24 hours per day, 7 days per week, 365 days per year. The only thing you need is a computer or mobile device with internet access and a camera.

Doctors on LiveHealth Online are available to diagnose and treat a wide variety of medical care needs. Some common items include the flu, a cold, sinus infection, pink eye, rashes and fever. When appropriate, the doctor can even prescribe medicine and send the prescription to the pharmacy of your choice. **The average cost of a doctor visit using LiveHealth Online is $59.**

Not only can you be seen by a medical doctor, you can also receive behavioral health services through LiveHealth Online. The behavioral health services can even be used in coordination with the eight free EAP counseling sessions. Below is a quick step-by-step guide on how you can take advantage of the free EAP sessions through LiveHealth Online.

- Call EAP at **800-223-7723** and select option one, State of Indiana Employee Assistance Program.
- Answer some general information, such as your name, date of birth and address.
- Ask the EAP representative about therapy visits.
- The EAP representative provides you with a **Service Key** and **Coupon Code** to be used in LiveHealth Online.



- Go to livehealthonline.com.
- Sign up or log in to LiveHealth Online.
  - To sign up: Download the mobile app from Google Play or the App Store. It is free and takes less than two minutes to download. Or visit www.livehealthonline.com and select the "Sign Up" button at the top right corner of the home page and create an account. All you need to provide is an email address (this becomes your user name), create a password, enter your first and last name, sex, state and agree to the terms of use. You are now registered and ready to connect to a provider.
  - OR, Log in by selecting the "Log In" button using your username (email address) and password.
- Select **Add a Service Key** in the **MY Services** section and enter the provided Service Key.
- Select **Work-Life Solutions EAP**, and choose the appointment tab. You can schedule an appointment by date or therapist. After scheduling the appointment, you receive a confirmation email.
- Fifteen minutes before your appointment you receive a reminder email. To initiate the appointment, you need to select on the "Start Visit" button, included in the email.
- Enter the Coupon Code in the payment screen for each of the eight free visits. This reduces the member cost share to $0.
- You are then connected to the therapist.

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

Vision

Vision Plan – Focus on Saving You Money

Vision and health conditions, such as diabetes and high blood pressure, can be revealed and detected early through a comprehensive eye exam. An annual exam with dilation will only cost you $10.00 at an in-network provider. Take care of your vision and overall health by taking the initiative to have an exam completed this year.

In addition to the exam, the plan allows for frames every 2 calendar years and lenses, including contact lenses, every calendar year. For frames the plan has a $150 allowance with a $25 standard lenses copayment when using an in-network provider.

Freedom Pass

To get the most of your money, you can utilize the Freedom Pass. Under the Freedom Pass, you can purchase frames at Target Optical and only pay up to the $150 frame allowance. Any balance over the $150 allowance will be waived. To receive the discount, all you need to do is provide Target Optical with the Offer Code 755285 or the Freedom Pass Flyer.

Fixed Copay

Fixed Copays for premium progressive and anti-reflective lens are another way the State is saving you money. Lens upgrades can fluctuate in cost significantly which can result in you spending more. By creating a fixed cost, you are guaranteed to spend only the fixed copay amount.

Reviewing Benefit Eligibility

To view your current eligibility for an exam, frames, lens or contact, please follow the below steps.

- Go to www.Anthem.com and log in to your account
- Place cursor over the "My Plan" drop-down menu on top of the page
- Select "Benefits" on the drop-down menu
- Select the box showing your current Vision benefit period
- Scroll down and select on the "View your vision benefit information" link
- On the new page, select the "View your Benefits" tab on top of the page
- Select Member
- Select the "Display Benefits" button on the bottom of the page
- Under the "Service Eligibility" section, you will find you current eligibility for an exam, frames, lens and contacts

Finding Care

Through Anthem Blue View Vision, you and your dependents have a large network of ophthalmologists, optometrists, opticians and retail locations to choose from. To find an in-network provider log onto www.Anthem.com. Place your cursor over the "Care" drop-down menu on top of the page and select "Care & Cost Finder". Then select the "Routine Vision" link under the "Other helpful searches and services" heading.

Dental

Enhanced Dental Benefits for 2021

Have you ever debated on whether to get a silver or a white filling? Next year, the decision may be a little easier. Beginning January 1st, composite (white) resin fillings will be covered at 80 percent for all teeth through a participating dentist. With this enhanced benefit, you will no longer be responsible for paying the difference in cost between the silver and white filling, which will save you money!

With this added benefit, there has never been a better time to get your annual dental cleaning. Studies have identified a link between oral health and chronic conditions such as heart disease. The best way to lower your risk is by keeping up on your preventive exams. Under the Anthem Dental Complete plan, your diagnostic and preventive services such as teeth cleanings, periodic oral exam and bitewing X-rays are covered at 100 percent when using an in-network provider. Other in-network services such as fillings, crowns and root canals are covered at 80 percent.

Similar to the other health plans, you can realize the greatest savings by going to an in-network dentist. While network dentists sign a contract with anthem to limit fees, nonparticipating dentists do not have limits on the amount they can charge you for services. If you decide to go to a nonparticipating dentist, be sure you understand your potential out-of-pocket costs before you receive services.

A list of dentists within the Dental Complete network can be found by logging onto www.Anthem.com. When logged in, place your cursor over the "Care" drop-down menu on top of the page and select "Care & Cost Finder". Then select the "Routine Dental" link under the "Other helpful searches and services" heading.

PeopleSoft Steps

PeopleSoft login and online self-service instruction guide

You can access your Open Enrollment event 24 hours, seven days per week from Wednesday, October 28th through Wednesday, November 18th at noon (EST). Keep in mind, you can access your Open Enrollment event from any computer that allows you access to the internet.

Helpful hints:

1. Your User ID is the first initial of your first name capitalized followed by the last six (6) digits of your PeopleSoft number. If you have forgotten your PeopleSoft number please contact your agency's Human Resources Department or the Benefits Hotline for assistance.
2. If you access the state network, the password used to log on to your computer can be used to log into PeopleSoft.
3. For password resets and unlocks please use the Self Service Password Management tool using the following link https://www.in.gov/password/ or you can use https://password.in.gov
4. For network connectivity or issues accessing the website, please contact IOT Customer Service at (317) 234-HELP (4357) or Toll-Free at 1-800-382-1095, and follow the menu options.
5. When making your elections in PeopleSoft, do not use the BACK / FORWARD arrow buttons at the top of your web browser.
6. Keep in mind you must turn off your "pop-up blocker" in order to print your Benefit Election Summary.
7. For any benefit related questions please call the Benefits Hotline at 317-232-1167 or Toll-Free at 877-248-0007 (if outside of the 317 area code).

IMPORTANT: Once you are satisfied with your Open Enrollment elections, it is essential you submit your elections and print a Benefit Election Summary for your records. As a reminder, the 2021 Non-Tobacco Use Agreement can only be accessed through the Open Enrollment event. Please do not attempt to elect to participate in the 2021 agreement by going through PeopleSoft Self-Service, as that platform is only used to revoke your current 2020 Non-Tobacco Use Agreement.

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

- https://hr.gmis.in.gov/psp/hrprd/?cmd=login&languageCd=ENG&
- http://myshare.in.gov/ and select the PeopleSoft HR link on the left side of the page

To view your current benefit elections, you need to log in to PeopleSoft and follow these steps:

- Select "Main Menu"
- Select "Self Service"
- Select "Benefits"
- Select "Benefit Summary"
- Your 2021 benefits will not be available to view until January 1, 2021.

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

Non-emergent Emergency Room visits may be denied

Did you know that more than 65% of all emergency room (ER) visits are not for life-threatening illnesses or injuries but for non-emergency medical concerns that could be treated at a doctor's office or urgent care center? Seeking treatment outside of the ER will save you both money and time. Below is a quick look at the cost difference between alternative treatment facilities.

Care Facility	Cost
Emergency Room	$1,200
Retail Health Clinic	$85
Walk-In Doctor's Office	$125
Urgent Care Center	$190

**Rates are national averages of the total cost, not what members paid. Your actual cost may vary depending on your plan and where you go for care.*

Non-emergency services are not covered when treated in an emergency room (ER), if more appropriate settings are available. ER claims are reviewed by Anthem using the prudent layperson standard and potentially denied. If your claim is denied, you will be solely responsible for the ER charges. Please note that non-emergency visits to the ER will be covered if:

- Directed to the emergency room by another medical provider
- Services were provided to a child under the age 14
- There isn't an urgent care or retail clinic within 15 miles
- Visit occurs on a Sunday or major holiday

As a reminder, Anthem's NurseLine is available 24/7 for those times you are not sure where you should seek medical care. If you are advised by the NurseLine to seek treatment at the ER and it is later determined that the visit was for a non-emergent visit, Anthem will approve the visit. To access NurseLine, please call 800-337-4770. When seeking medical care, consider all your options.

New membership ID cards

All State of Indiana health plan participants will receive a new ID card in the mail for the 2021 plan year. Each family member will receive their own unique card prior to January 1st with their name. As in the past, the cards will be used for medical, prescription, dental and vision. To ensure that you receive your new card timely, take the time to review your address in PeopleSoft and update it as necessary.

Please continue to use your current card for any health or prescription services received before January 1, 2021. Beginning January 1st please present your new ID card to your provider or pharmacy.

To ensure that you receive your new membership ID card timely, please review and update, as necessary, your contact information within your Open Enrollment event.

2021 Benefits Open Enrollment

Oct. 28 - Nov. 18

Deadline is Wednesday, Nov. 18 by noon EST

www.in.gov/spd/OpenEnrollment

Artwork by Jerry Williams

Health Savings Account (HSA)

State continues to contribute to Health Savings Account

The state will continue to contribute approximately 45 percent of the Consumer Driven Health Plan (CDHP) annual deductible to your Health Savings Account (HSA) in 2021. The initial contribution will be made on your January 06, 2021 paycheck. Employees enrolled in a CDHP effective from January 1, 2021 through June 1, 2021 receive the full pre-fund amount. CDHPs effective on or after June 2, 2021, but before December 2, 2021, receive one-half of the initial contribution. The initial pre-fund contribution is based on the coverage type (single/family) that is effective January 1, 2021 or your first day of coverage in a state health plan during 2021.

Plan	2021 Initial Contribution	2021 Bi-Weekly Contribution	Annual Employer Contribution
HSA 1 Single	$562.38	$21.63	$1,124.76
HSA 1 Family	$1,124.76	$43.26	$2,249.52
HSA 2 Single	$393.90	$15.15	$787.80
HSA 2 Family	$787.80	$30.30	$1,575.60

If you have an active HSA with The HSA Authority at Old National Bank and wish to continue receiving the state's contributions in 2021, you do not need to open a new HSA account. **Employee HSA contribution amounts do not carry over from year to year. If you would like to contribute to your account during 2021, you need to access your PeopleSoft record and enter your desired contribution.**

If you are electing to participate in an HSA for the first time in 2021, you must edit the online HSA option in PeopleSoft and choose the HSA that corresponds to your medical CDHP election in order to receive the state's contribution. In addition to electing the HSA option, you need to open an HSA account with The HSA Authority before January 1, 2021.

As a reminder, to be eligible for an HSA you:

- Must be currently enrolled in an HSA-qualified health plan;
- May not be enrolled in any other non-HSA qualified health plan;
- May not have, or be eligible to use, a general purpose Flexible Spending Account (FSA);
- Cannot be claimed as a dependent on another person's tax return;
- May not be enrolled in Medicare, Medicaid, HIP or Tricare;
- Must not have used VA benefits for anything other than preventative services in the past three months.

  *Please note: veterans with a disability rating are eligible to participate in an HSA if all of the other criteria are met.

To open your HSA, link to The HSA Authority's website from PeopleSoft on your HSA election page, or go directly to www.theHSAauthority.com and select on the "OPEN AN HSA" button. The first page of this online session says: "If you have been instructed by your employer to visit this site to open your HSA, select this button and insert your employer code below". Enter 100366 in the "employer code" to begin the state application. You need the following information to complete the HSA application online:

1. Driver's license
2. Social Security number, date of birth and address for your beneficiaries
3. Social Security number, date of birth and address for your authorized signer (if selected)
4. Security passwords for you and your authorized signer (based on the answer to one of the five questions you select during the application

HSAs have a maximum contribution limit

Contributions are allowed up to the maximum statutory limit. The maximum annual contribution for 2021 is $3,600 for self-only policies and $7,200 for family policies.

Individuals age 55 and over may make an additional catch up contribution of up to $1,000 in 2021.

Combined household contributions cannot exceed the family limit. The maximum includes the state's contributions and any other contributions to your HSA.

Plan	Coverage	IRS Maximums	State Contribution	Max EE Contribution	Max Bi-Weekly	Max EE Contribution Over 55	Max Bi-Weekly Over 55
HSA 1	Single	$3,600	$1,124.76	$2,475.24	$95.20	$3,475.24	$133.66
	Family	$7,200	$2,249.52	$4,950.48	$190.40	$5,950.48	$228.86
HSA 2	Single	$3,600	$787.80	$2,812.20	$108.16	$3,812.20	$146.62
	Family	$7,200	$1,575.60	$5,624.40	$216.32	$6,624.40	$254.78

Health Savings Account (HSA)

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

The IRS established Health Savings Accounts (HSAs) as a method to provide individuals a tax advantage to offset their health care costs. In doing so, the IRS created eligibility criteria to qualify for the account. Enrolling in Medicare, Medicaid or HIP disqualifies you from having contributions into an HSA. Once enrolled in any of these plans, you may not receive or make any contributions into an HSA.

Although you can no longer make contributions to your HSA once you are covered by Medicare, Medicaid or HIP, the money accumulated in your HSA from past years remains yours to spend, tax-free, on eligible expenses, including Medicare copays or deductibles, vision expenses and dental expenses. If you are age 65 or over, you also have the option to withdraw the money for any purpose and pay only the income tax without penalty. The same rules also apply if you receive Social Security disability benefits and are enrolled in Medicare.

Please review the below information carefully as it relates to your eligibility to qualify for an HSA.

Medicare

If you elect to receive Social Security Benefits, you are automatically enrolled in Medicare Part A when you turn age 65. If you wish to participate in a Health Savings Account (HSA), you should decline to receive Social Security retirement benefits and waive Medicare Part A. Keep in mind there are potential consequences if you choose to decline or postpone your enrollment. Additionally, if you decided not to take Medicare when you first qualify, please be advised that your Medicare Part A start date may backdate up to six months when you apply for Social Security benefits. Please carefully research all of your options before making your decision.

You can use funds in your HSA to pay for incurred eligible medical expenses for your dependents (as defined by federal regulations), even if they are not covered under your medical plan, or have other coverage, such as Medicare. However, keep in mind that if your spouse is on Medicare, she/he is not eligible to contribute to an HSA in her/his name, regardless of whether or not she/he is covered on your medical plan.

Medicaid and HIP

According to IRS regulations, an individual who is enrolled in Medicaid or HIP is not eligible to make or receive contributions to an HSA. There are tax consequences to both the individual and the employer, if the employer is also contributing to an HSA for the employee. Similar to Medicare, if your dependent(s) is/are covered by Medicaid or HIP but you are not, you may continue to receive contributions to your HSA. Eligibility is based on the subscriber/ account holder.

Federal Notice

State plans provide creditable coverage

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

Second, it has been determined that the prescription drug coverage offered as a part of the State of Indiana employee health plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

Flexible Spending Account (FSA)

Flexible Spending Accounts

Medical Care & Limited Purpose FSA Maximum Contribution Limit Increasing

A Flexible Spending Account (FSA) provides another opportunity for you to better control your health care dollars. By tucking away pre-tax dollars from your paycheck, you have an account that is dedicated to the reimbursement of qualified medical, vision and dental expenses. In addition, the bi-weekly employee administration fee is paid by the state during the 2021 plan year, providing you with even more opportunities to save.

Through ASIFlex, the State will continue to offer three types of FSAs: Medical Care, Limited Purpose Medical Care and Dependent Care. If you wish to participate in a FSA for the 2021 plan year, you must re-enroll as your previous election will not roll-over. If you continue participation, do not discard the debit card from ASIFlex. New cards are not automatically issued each year.

As a reminder, all of the state's FSA programs have a use-it-or-lose-it rule. Money left at the end of the plan year is not rolled over or reimbursed, so plan carefully. Please note, if you have funds remaining in your 2020 account, you may continue to submit claims for reimbursement through ASIFlex until the Grace Period expires.

Medical Care & Limited Purpose FSA

Medical Care and Limited Purpose FSAs allow employees to use pre-tax dollars to cover health care costs for medical, dental, vision, hearing and other out-of-pocket expenses not paid by insurance. For 2021, the annual contribution limit for the Medical Care and Limited Purpose FSAs will be increasing to $2,750. A Limited Purpose FSA may only be used for dental, vision and preventive care expenses until the minimum deductible of a Consumer Driven Health Plan (CDHP) is met ($1,400 for single and $2,800 for family, per federal regulations). Once the minimum deductible is met, the Limited Purpose FSA can be used as a Medical Care FSA. If you are enrolled in a CDHP with a Health Savings Account (HSA), your FSA automatically becomes a Limited Purpose FSA. You do not need to meet the minimum deductible to use the funds in your Limited Purpose FSA for dental and vision expenses. You can pay for dental and vision expenses from your Limited Purpose FSA at any point during the year.

Dependent Care FSA

A Dependent Care FSA is used to pay for dependent care services such as preschool, summer day camp, before or after school programs and child or elder daycare. Dependent care expenses do not include medical expenses and therefore can be used even if you participate in an HSA.

Dependent Care FSAs are not frontloaded. Portions of your biweekly pay are put into a pre-tax account to pay for eligible dependent care costs throughout the year. Currently, the maximum annual contribution amount for the Dependent Care FSA is $5,000 ($2,500 if married and filing separate tax returns).

Should you have any questions about your flexible spending accounts, please contact Indiana State Personnel Benefits at 317-232-1167 or toll free at 877-248-0007. You may also contact ASIFlex customer service via phone at 800-659-3035 Monday through Friday from 8 a.m. to 8 p.m. EST and from 10 a.m. to 2 p.m. EST on Saturday. ASIFlex may also be reached by email at asi@asiflex.com.

Flu Shot

CVS partners with the state to offer flu vaccine

The number one way to protect yourself and your family from the flu this year is to get a flu vaccination. According to a research study by the Centers for Disease Control and Prevention (CDC), the flu vaccine reduces the risk of getting the flu by 40% to 60%. While the vaccine does not guarantee you won't catch the flu, it does reduce the chances and, if you do get sick, your illness typically is milder. Since influenza viruses change over time, it is important to get a shot every year. Each year the vaccine is remade to include the types of flu virus expected to cause illness during that flu season. The vaccine begins to protect you within a few days after vaccination, but the vaccine is not fully effective until about 14 days after vaccination.

As part of your State of Indiana medical benefits, preventative vaccinations, such as the flu shot, are covered 100% before the deductible. This means that you and your covered dependents can receive the flu shot for free. You can receive the shot at your primary care provider, or at retailers such as CVS, Kroger, and Costco.

If you do not carry State employee insurance this year, you may still receive a flu shot. The cost of the vaccine is $39.99 if you are under the age of 65 and $69.99 for those aged 65 and older.

Commuter Benefit Reimbursement Account

Commuter Benefit Reimbursement Account

Do you currently commute to work by train, vanpool, subway, or some other type of mass transit? If so, a Commuter Benefits Reimbursement Account may be just what you have been looking for. Through the Commuter Benefits Reimbursement Account administered by ASIFlex, you can set aside money from your paycheck, pretax, to pay for work-related commuting expenses.

Each month you can contribute up to a maximum of $265. Reimbursements are made from the pretax contributions you previously had deducted from your paycheck. To utilize the benefit, present your ASIFlex debit card as payment to any transit provider who accepts VISA debit cards. You may also seek reimbursement by completing a claim form. Reimbursements are made within three days following receipt of the completed claim form. Best of all, you can sign up, change your contribution amount, or terminate your account at any time by calling the Benefits Hotline.

If you do not spend the full amount you contributed for the month, the money will roll over month to month and year to year. You can then use the funds for future expenses. Claims can be submitted at any point in time as long as you are still actively contributing to the Commuter Benefit Reimbursement Account. Once you terminate your participation in the program, or leave State employment, you must submit all claims within six months of your termination date in order to be reimbursed.

Eligible expenses are those you incur to commute to and from your place of employment. This includes bus, ferry, rail, monorail, streetcar, trolley, train, subway or vanpool. A Vanpool is considered a highway vehicle with seating capacity of at least six adult passengers. At least 80% of the mileage must be for commuting and the number of employees transported must be at least half of the adult seating capacity.

Eligible expenses do not include bicycle or repairs, non-work related parking or transit/vanpool expenses, gas or fuel, tolls, or vehicle repairs.

Please note, if you are already enrolled in the Commuter Benefit Reimbursement Account, your election from 2020 will carry over to 2021, unless you waive your coverage.

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

Non-Tobacco Use Incentive

Non-Tobacco Use Incentive

The Non-Tobacco Use Incentive is offered again for the 2021 plan year. Receive a $35 reduction in your group health insurance bi-weekly premium by accepting the agreement during Open Enrollment. By accepting the incentive, you agree to not use any form of tobacco products in 2021. Keep in mind, by accepting the agreement you agree to be subject to testing for nicotine at any time during the year. If you test positive for nicotine you will be presumed to be in violation of the policy. Tobacco use means any use of tobacco whether smoked, chewed, sniffed, or ingested in any other manner, including food or drink. Only proof of use of an FDA approved Nicotine Replacement Therapy product will be accepted as evidence to rebut the presumption of a breach.

For more information on FDA approved Nicotine Replacement Therapy Options, visit the FDA's website, here.

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

The Non-Tobacco Use Incentive is only available to employees who have enrolled in medical coverage. You do not have access to the agreement if you waive medical coverage for plan year 2021. The reduction in your group health insurance bi-weekly premium only applies to your employee medical premium, and does not apply to dental, vision or life insurance premiums.

If you accept the NTUA during Open Enrollment and later use tobacco or otherwise breach the NTUA, your employment will be terminated, for breach of the agreement and inappropriately taking the $35 bi-weekly premium reduction. The only exception to the job loss penalty is if you revoke the NTUA by logging in to PeopleSoft and completing the self-service process to change your agreement prior to the use of any tobacco product. If you need to revoke your agreement and are not sure how to complete the process in PeopleSoft, call the Benefits Hotline and a specialist can walk you through it. If you revoke the NTUA, you are responsible for paying the value of the incentive you have received for the year. The $910 is a great incentive, but **it certainly isn't worth losing your job!**

If you use FDA approved nicotine replacement therapy products, please keep all of your receipts for these products and/or copies of prescriptions from your physician to demonstrate your compliance with the NTUA.

The Non-Tobacco Use Incentive does not carry over from year to year. If you want to participate in 2021, you must access your Open Enrollment event within PeopleSoft and accept the NTUA.

Notice: If your physician determines abstaining from the use of tobacco is not medically appropriate, a reasonable alternative standard is made available for the incentive.

Life Insurance

Review & update your life insurance beneficiary information

Open Enrollment is a great time to review your current life insurance beneficiary information. It only takes a couple of minutes to verify your beneficiary designations and update their contact information in your Open Enrollment event. By routinely checking this information you are assuring you have allocated your life insurance benefits as desired, since certain life events such as marriage, divorce, birth or death may change how you want your benefits paid out.

In addition to confirming your beneficiary allocation, you should also update their contact information. It is extremely important PeopleSoft has the correct addresses and phone numbers for all of your beneficiaries. This information is used to identify and locate your designated beneficiaries if a claim is processed. Without updated contact information it may take a significantly longer period of time to pay out a claim.

Notify your Beneficiaries

Once you have designated your beneficiaries, it is a good idea for you to notify them of your policy and your decision to list them as a beneficiary. Under Indiana State Personnel's policy, we will not share coverage amounts or beneficiary information to anyone besides you as the policy holder. Providing policy information to your beneficiaries prior to a claim occurring makes a difficult situation easier to cope with, especially when dealing with the financial aspect of the loss.

Note: All beneficiary changes made within your Open Enrollment event take effect on January 10, 2021 unless you are employed with a direct bill agency, in which case your changes will be effective January 1, 2021.

Federal Notice

Women's Health & Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. If you would like more information on WHCRA benefits, contact Anthem at 1-877-814-9709.

Federal Notice

HIPAA Notice of Special Enrollment Rights

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

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

Eligible employees and dependents may also enroll under two additional circumstances:

- The employee's or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The employee or dependent becomes eligible for a subsidy (state premium assistance program)

The employee or dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

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

Life Insurance

Life Insurance - Are you prepared?

Life insurance is something no one wants to think about but is important to have. The State of Indiana makes having coverage easier by offering four types of coverage: basic, supplemental, voluntary AD&D and dependent life insurance. During this Open Enrollment, take the time to review your finances and consider which option and coverage amount is best for you and your family.

Some life insurance changes can be completed within your Open Enrollment event. These changes include:

- Electing or increasing voluntary AD&D coverage
    - Must be currently enrolled in basic life insurance with AD&D
- Electing or increasing child dependent life insurance
    - Must be currently enrolled in basic life insurance with AD&D
- Decreasing your coverage level
- Waiving your life insurance plans
- Updating your beneficiary information and/or allocation amounts
    - All changes are effective in January 2021

Outside of Open Enrollment you may acquire or make changes to your life insurance plans by completing the

Evidence of Insurability (EOI) process at any time throughout the year. Allowable changes include adding or increasing your coverage level and/or adding an eligible spouse to your dependent life insurance plan. This process applies to the basic, supplemental and spouse dependent life policies.

The EOI application can be completed online at any time. On average the application takes 10 to 30 minutes to complete. Instructions on how to submit EOI through Securian can be found here. Once submitted, Securian reviews your application and informs both you and SPD Benefits of its decision. If approved, SPD Benefits makes the appropriate changes to your life insurance plans and starts the premium deductions.

Please keep in mind, you may also make changes to your beneficiary information at any point during the year by accessing PeopleSoft self-service. Instructions on how to change your life insurance beneficiaries can be found here. Please remember, you are the only one who can change your beneficiary information.

Reminder: Supplemental life insurance is offered to most employees in increments of $10,000 up to and including $500,000, regardless of salary level. Employees reaching age 65 or older on or before December 31, 2020, are limited to $200,000 of supplemental life insurance coverage. Employees reaching age 65 during the plan year are automatically reduced to $200,000 of supplemental life insurance coverage and their payroll deductions are adjusted accordingly.

Annual Physical

Don't Forget to Schedule Your Annual Physical for January

It is important to remember to set some time aside to get your annual physical. Now is the perfect time to schedule your January appointment. Similar to this year, both you and your spouse can each earn a $100 gift card in 2021 by completing a physical with lab work and submitting a "Provider Form" to ActiveHealth. To access the form, log in to the ActiveHealth portal during 2021 and select the "Provider Form and Instructions" from the home screen.

It is easy to get in the mindset that you don't need a physical if you don't feel sick. However, having an annual physical is one of the best ways to maintain your health. Preventive care, such as an annual physical can help identify underlying health concerns before they become a major issue. By routinely visiting your doctor, you can establish a baseline on your health statistics regarding your weight, height, blood sugar, blood pressure and cholesterol. In addition, you are able to keep your doctor informed about your family's changing medical history. By doing so, your doctor will be able to identify any significant changes in your health statistics or concerns based on your family history that could indicate a problem. Once identified, an early treatment plan can be established to prevent the condition from getting worse.

Outside of identifying health conditions, having an annual physical is a great way to ensure that you are up-to-date on all of your vaccinations to maintain your health. Likewise, your doctor can recommend preventive care goals based on your current health to assist you in continuing down a path of healthy living. Overall, an annual physical is one of the easiest things you can do to maintain a healthy lifestyle. To find an in-network doctor near you, please follow the below steps.

- Log in to www.Anthem.com
- Hover over the "Care" tab on top of the page
- Select "Care & Cost Finder"
- Select "Primary care" under the "Other helpful searches and services

Dependent Eligibility

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

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

We recommend you access PeopleSoft during Open Enrollment to review or edit your dependent information. Keep in mind, you have to enroll your dependents on each plan (medical, dental and vision) for which you desire coverage.

Disabled Dependents

Disabled dependents can be enrolled in any of your desired plans during the Open Enrollment period if they have not exceeded the month in which they turn 26 or were approved through the Anthem recertification process. If you wish to enroll a dependent during Open Enrollment who is over the age of 26 and meets the definition of a disabled dependent, but was not certified through Anthem, please call the

Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007, if outside of Marion County.

Upon your request, Anthem will be notified to mail you an Application for Continuation of Coverage. This form must be completed and returned to Anthem within 30 days of the issue date. If Anthem certifies your dependent meets the definition of a disabled dependent, the state will then enroll your dependent in your plans with the effective date of January 1, 2021.

Please note, you must initiate the certification process by contacting the Benefits Hotline during Open Enrollment to be eligible to enroll your dependent(s) as part of your Open Enrollment event for an effective date of January 1, 2021.

Outside of Open Enrollment, you may only add a disabled dependent through a qualifying event. Similar to the process outlined above, you must contact the Benefits Hotline to initiate the certification process. Notification must be done within 30 days of the qualifying event.

Please note: In order for a disabled dependent to continue coverage past the month in which they turn 26 years of age, you must contact the Benefits Hotline to initiate the certification process. Notification must be done within 30 days from your dependent turning 26-years old. To be eligible, a dependent child must have been deemed disabled prior to age 19. If a dependent child was deemed disabled after age 19, they are not eligible to continue coverage past the month they turn age 26.

Making Changes

Qualifying events allow for changes

After noon (EST) on Wednesday, November 18th you are not able to make further changes to your benefits. This means you must be certain you elect the coverage that is right for you and add all eligible dependents you wish to cover to all plans (medical, vision and dental). After Open Enrollment, you can only make changes in conjunction with a qualifying event.

Qualifying events are regulated and defined by the IRS. Examples include:

- Changes in your legal marital status (marriage, divorce, separation, annulment or death of spouse).
- Changes in the number of dependents (birth, adoption, placement for adoption or death).
- Changes in employment status for you or your spouse, such as termination of or change in employment, a strike or lockout, or the start or end of an unpaid leave of absence.
- Changes in dependent eligibility status (such as attainment of limiting age).

If you do not report a qualifying event within 30 calendar days from the date of the qualifying event, you are not able to add dependents until the next Open Enrollment period. Please note that an ex-spouse is ineligible for coverage as of the day of divorce. **It is important that you report ineligible dependents even if it is beyond the 30 day period to minimize recovery of claims.**

Affordable Care Act: Section 6055 and 6056

In accordance with Section 6055 and 6056 of the Internal Revenue Code under the Affordable Care Act (ACA), the state is required to file health coverage information to the IRS by completing an information return along with furnishing statements to individuals who are or have been employed by the state during the year. The IRS will use the information gathered to determine if the employee was in compliance with the individual shared responsibility provision in section 5000A.

Under the Affordable Care Act large employers, such as the State of Indiana, are required to request dependent social security numbers for use in completing IRS forms, 1094-C and 1095-C. Listed below are four methods in which you may report this information to the Benefits Division.

Phone/Fax

- 317-232-1167 (Indianapolis area)
- 877-248-0007 (outside Indianapolis)
- Fax - 317-232-3011

Mail

- State Personnel Department Attn: Benefits Division. 402 W Washington St. Room W161 Indianapolis, IN 46204-2261

PeopleSoft Self Service

- Go to www.in.gov
- Select State Employee Resources
- Select PeopleSoft HR
- Log in using your unique user ID and password
- Select Main Menu
- Select Self Service
- Select Benefits
- Select Dependent/ Beneficiary Info
- Select Edit
- Enter the SSN
- Select Save
- Sign out of PeopleSoft
  All names and social security numbers in PeopleSoft must match the information listed on you and your dependents social security card. If you decide to report the information via phone, fax or email you must provide the Benefits Division with a copy of your social security card along with your dependents. It is your responsibility to ensure that the correct information is in PeopleSoft for you and all of your dependents. If it is identified that PeopleSoft has an incorrect name or social security number on file for either you or one of your dependents, you will be required to provide documentation to State Personnel Benefits to correct your record. Please note, if you do not provide your dependent's social security number the IRS may be unable to match the information you provide on your tax return. This may result in receiving an inquiry from the IRS or being liable for a shared responsibility payment.

If you have any questions regarding this notice, please do not hesitate to call the Benefits Hotline at 317-232-1167 or toll free at 877-248-0007 (if outside of Indianapolis).

Federal Notice

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).

Coverage

Make sure your dependents are eligible

Dependents of eligible employees may be covered under the state's benefit plans. Please see the below definition of a dependent.

(1) "Dependent" means:

(a) Spouse of an employee;

(b) Any children, step-children, foster children, legally adopted children of the employee or spouse, or children who reside in the employee's home for whom the employee or spouse has been appointed legal guardian or awarded legal custody by a court, under the age of twenty-six (26). Such child shall remain a "dependent" for the entire calendar month during which he or she attains age twenty-six (26). In the event a child:

i.) was defined as a "dependent", prior to age 19, and

ii.) meets the following disability criteria, prior to age 19:

(I) is incapable of self-sustaining employment by reason of mental or physical disability,

(II) resides with the employee at least six (6) months of the year,

and

(III) receives 50% of his or her financial support from the parent

Such child's eligibility for coverage shall continue, if satisfactory evidence of such disability and dependency is received by the State or its third party administrator in accordance with disabled dependent certification and recertification procedures. Eligibility for coverage of the "Dependent" will continue until the employee discontinues his coverage or the disability criteria is no longer met. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible Dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required. The plan requires periodic documentation from a physician after the child's attainment of the limiting age.

When completing your Open Enrollment, please make sure you carefully review the dependents listed on your summary. **Enrolling dependents who are ineligible for medical, dental, or vision insurance will result in your dismissal from employment.** Additionally, if a dependent becomes ineligible for coverage during the year, you must notify Indiana State Personnel Benefits within thirty (30) days of the dependent becoming ineligible. **Maintaining coverage on dependents who become ineligible during the plan year may result in disciplinary action.**

Please Note: If you have questions or concerns about dependent coverage, or wish to enroll a dependent on your plans during Open Enrollment who is over age 26 and meets the definition of a disabled dependent but was not certified through Anthem, call the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007, if outside the 317 area code, to initiate the disabled dependent certification process. **To be eligible to enroll your dependent(s) as part of your Open Enrollment event for an effective date of January 1, 2021, you must contact the Benefits Hotline during Open Enrollment and Anthem must certify that your dependent(s) meets the definition of a disabled dependent.**

Coverage

Dual coverage is not allowed under any benefit plan

Dual coverage of the same individual is not allowed under the state's medical, dental and vision benefit plans. For example, if both you and your spouse are state employees with insurance coverage (or one is a current employee and the other is a retiree), you may not cover each other on both plans or have the same children on family coverage. This also applies to parents of children who are not married to each other. You may each elect a single plan, one may carry family 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 have the choice to continue your retiree coverage and waive your active employee coverage, or vice versa. However, you are not permitted to carry state retiree insurance and active state employee coverage simultaneously. Dual coverage is only permitted for dependent life.

NOTICE OF INDIANA STATE EMPLOYEE GROUP INSURANCE PLAN PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how protected health information (or "PHI") may be used or disclosed by our Group Health Plans to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your PHI, and describes your rights to access, amend and manage your PHI.

PHI is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices had been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact our Benefits staff (317) 232-1167 (Indianapolis) or (877) 248-0007 (outside Indianapolis).

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your PHI. We are obligated to: provide you with a copy of this Notice of our legal duties and of our privacy practices related to your PHI; abide by the terms of the Notice that is currently in effect; and notify you in the event of a breach of your unsecured PHI. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will make the revised Notice available by giving you information where to find the amended Notice on our company intranet, on the worldwide internet, or by providing you with a paper copy.

Permissible Uses and Disclosures of PHI

The following is a description of how we are most likely to use and/or disclose your PHI.

Payment and Health Care Operations

We have the right to use and disclose your PHI for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

Payment

We will use or disclose your PHI to pay claims for services provided to you and to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your PHI when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

Health Care Operations

We will use or disclose your PHI to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, underwriting,

business planning, and business development. For example, we may use or disclose your PHI: (i) to provide you with information about a disease management program; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

Other Permissible Uses and Disclosures of PHI

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your PHI.

Required by Law

We may use or disclose your PHI to the extent the law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

Public Health Activities

We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

Health Oversight Activities

We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Abuse or Neglect

We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence.

Legal Proceedings

We may disclose your PHI: (i) in the course of any judicial or administrative proceeding; (ii) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

Law Enforcement

Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (i) it is required by law or some other legal process; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on our premises.

Coroners, Medical Examiners, Funeral Directors; Organ Donation Organizations

We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

Research

We may disclose your PHI to researchers when an institutional review board or privacy board has: (i) reviewed the research proposal and established protocols to ensure the privacy of the information; and (ii) approved the research.

To Prevent a Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security, Protective Services

Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

Inmates

If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (i) the institution to provide health care to you; (ii) your health and safety and the health and safety of others; or (iii) the safety and security of the correctional institution.

Workers' Compensation

We may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Emergency Situations

We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will disclose only the PHI that is directly relevant to the person's involvement in your care.

Group Health Plan Disclosures

We may disclose your PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to you. We can disclose your PHI to that entity if that entity has contracted with through us for your health care program.

Underwriting Purposes

We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing in the underwriting process your PHI that is genetic information.

Others Involved in Your Health Care

Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

<u>Uses and Disclosures of Your PHI that Require Your Authorization</u>

Psychotherapy Notes

We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be

effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

Required Disclosures of Your PHI

The following is a description of disclosures that we are required by law to make.

Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

Disclosures to You

We are required to disclose to you most of your PHI in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

We will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose PHI to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

Business Associates

We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management. Examples of our business associates would be our Third Party Administrators which will be handling many of the functions in connection with the operation of our Group Health Plan; retail pharmacy; mail order pharmacy; insurance companies where applicable; managed care organizations; etc.

Other Covered Entities

We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

Plan Sponsor

We may disclose your PHI to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

YOUR RIGHTS

The following is a description of your rights with respect to your PHI.

Right to Request a Restriction

You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. *We are not required to agree to any restriction that you may request.* If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you. You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for restriction to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

Right to Request Confidential Communications

If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for confidential communications to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your PHI with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your PHI could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (*e.g.*, an Explanation of Benefits, or "EOB"). *Unless* you have made other payment arrangements, the EOB (in which your PHI might be included) will be released to the plan participant.

Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within five business days.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI might be disclosed (such as through an EOB). Therefore, it is extremely important that you contact the designated contact listed on the first page of this Notice *as soon as* you determine that you need to restrict disclosures of your PHI.

If you terminate your request for confidential communications, the restriction will be removed for *all* of your PHI that we hold, including PHI that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your PHI will endanger you.

Right to Inspect and Copy

You have the right to inspect and copy your PHI that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your PHI that is contained in a designated record set, you must submit your request to the designated contact listed on the first page of this Notice. It is important that you contact the designated contact to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the designated contact might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact the designated contact listed on the first page of this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

Right to Amend

If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by contacting the designated contact listed on the first page of this Notice. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to the designated contact so that we can begin to process your request. Requests sent to persons or offices, other than the designated contact might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

Right of an Accounting

You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to the designated contact listed on the first page of this Notice. It is important that you direct your request for an accounting to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

Right to a Copy of This Notice

You have the right to request a copy of this Notice at any time by contacting the designated contact listed on the first page of this Notice. If you receive this Notice on our Website or by electronic mail, you also are entitled to request a paper copy of this Notice.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at the number listed on the first page of this Notice or direct the complaint to Privacy Officer, State Employee Group Insurance Plan, State Personnel Department, W161, Indiana Government Center South, 402 West Washington Street, Indianapolis, IN 46204.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or any other way retaliate against you for filing a complaint with the Secretary or with us.

DISCRIMINATION IS AGAINST THE LAW

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

State of Indiana Employee Health Plans:

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

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-248-0007 (TTY: 1-317-232-4555).

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ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-248-0007 (TTY: 1-317-232-4555).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-248-0007 (TTY: 1-317-232-4555).

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။

ဖုန်းနံပါတ် 1-877-248-0007 (TTY: 1-317-232-4555) သို့ ခေါ်ဆိုပါ။

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-248-0007 (رقم هاتف الصم والبكم: 1-317-232-4555).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-248-0007 (TTY: 1-317-232-4555)번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-248-0007 (TTY: 1-317-232-4555).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-248-0007 (ATS : 1-317-232-4555).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-248-0007（TTY:1-317-232-4555）まで、お電話にてご連絡ください。

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-877-248-0007 (TTY: 1-317-232-4555).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-248-0007 (TTY: 1-317-232-4555).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-248-0007 (телетайп: 1-317-232-4555).

ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਿਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਧਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਿ ਹੈ। 1-877-248-0007 (TTY: 1-317-232-4555) 'ਤੇ ਕਾਲ ਕਰੋ।

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-248-0007 (TTY: 1-317-232-4555) पर कॉल करें।

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: **http://www.dol.gov/vets/programs/userra/poster.htm**. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date — April 2017

NOTICE REGARDING WELLNESS PROGRAM

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

If you choose to participate in the wellness program you will be encouraged to complete:

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

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

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

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

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

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the State of Indiana may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable

accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

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

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

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, or complaints about the wellness program, please contact the Benefits Hotline: SPDBenefits@spd.in.gov or 877-248-0007.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number.

The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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