



The Torch

The official newsletter for State of Indiana employees

Open Enrollment Edition

Choose the
Right Coverage
for You

2025 Open Enrollment

Oct. 30 – Nov. 20
by noon ET

Enroll online starting Oct. 30

This special edition of The Torch is dedicated to the 2025 Open Enrollment. Please review all the information concerning your health care coverage. During this period, from Oct. 30 to Nov. 20, you can choose to make additions or

changes to your benefit selections.

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

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

Eligibility for 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 37.5 hours per week.






Part-time and intermittent (temporary) employees who work an average of 30 or more hours per week over a 12-month review period are eligible for medical, prescription, and HSA benefits only. Part-time and intermittent (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.

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The Torch is published monthly by the Indiana State Personnel Department and is available online at on.in.gov/TheTorch.

Open Enrollment Quick Links

-  [2025 Plan Rates](#)
-  [Health Plan Options](#)
-  [Health Savings Account](#)
-  [Dental](#)
-  [Vision](#)

Benefit highlights for 2025

What is changing for 2025

- Premiums for all three health plans have been adjusted to keep pace with rising healthcare costs while still providing the best benefits to employees.
- Health Savings Account (HSA) contribution limits are increasing to \$4,300 for single and \$8,550 for family. This is the maximum amount that can be contributed to an HSA and includes both employee and employer contributions.
- Flexible Spending Account maximum is increasing to \$3,200 annually.
- The maximum limit on Supplemental Life is increasing from \$500,000 to \$750,000. To increase your Supplemental Life insurance, you must complete the Evidence of Insurability (EOI) process and be approved. To submit EOI, please visit: www.LifeBenefits.com/SubmitEOI.

What is staying the same

- The state will offer three health plans: CDHP 1, CDHP 2, and the Traditional Plan. The plans will be tiered, with Anthem's HealthSync as the Tier 1, lowest cost option.
- Deductibles, co-insurance amounts, and out-of-pocket maximums for all three health plans.
- The state's health savings account (HSA) contribution amount to each plan.
- Non-Tobacco Use Incentive, \$35 bi-weekly discount off the medical plan premium.
- The prescription drug coverage plan design. All three plans will have prescription drug coverage through CVS Caremark and prescriptions are paid as Tier 1.
- Dental and Vision premiums.
- The Flexible Spending Account administrative fee will be paid by the state.

When do my 2025 Open Enrollment changes take effect?

Medical, dental, vision, life insurance, flexible spending account changes/enrollments:

- Effective: Jan. 1, 2025
- First deduction: Jan. 15, 2025

Direct bill agency employees - For deduction information, please see your agency's Payroll Department.

Choose the

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2025 Open Enrollment

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Subscribe to INSPD's communication channels to stay informed about 2025 Open Enrollment.

Publications:

[The Torch](#) • [Around the Circle](#)

Web: in.gov/spd/OpenEnrollment

Text: [Benefits alerts](#)

Checklist

The 2025 Open Enrollment checklist

Is your current plan still the right plan for you? Now is the perfect time to review your options, look at your family's current health and finances, and choose the right coverage for you.

To make the election process easier, several resources are available to help you estimate your 2025 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, 2025.
- Access your HR PeopleSoft account. [View the quick-step guide](#) for instructions about how to complete your Open Enrollment.
- Confirm or update personal information, including your home and/or mailing address, e-mail address, and phone number.
- Confirm your Non-Tobacco Use Agreement. Your agreement will roll over from 2024. If you accept or continue to accept the agreement, you are agreeing to all the conditions of the Non-Tobacco Agreement for the 2025 plan year. **Note: You must accept or decline the Non-Tobacco Agreement to elect a medical plan.**
- You must select the health savings account plan that matches the medical plan option you selected, or you will receive a warning message.
- To cancel your insurance coverage, you must select "waive." As a reminder, if you waive your medical coverage, you must also waive your non-tobacco agreement and health savings account.**
- 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 your benefit plans and report their eligibility change to the Benefits Hotline.
 - Carefully enter personal information for new dependents and/or beneficiaries (information must match what is on their Social Security card).
 - Add your dependents' Social Security numbers.
 - For dependent/beneficiary name changes and Social Security number corrections, please contact the Benefits Hotline. Please do not add the dependent again.
- 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) and wish to contribute, 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 2025 unless you waive the coverage.
- Your benefit elections have been successfully submitted if the status under the Enrollment Summary page shows "Submitted."
- If your status under the Enrollment Summary shows "Changes saved – Submit to view," you need to select the Submit Enrollment button as you have made changes since the last time you submitted your enrollment. These changes have been saved and submitted but will not be reflected on your Election Preview unless you select the Submit button.
- Be sure to print an **Election Preview** 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, Monday through Friday, 7:30 a.m. to 5 p.m. ET.

Medical - No plan changes for 2025

Now is the time to carefully review all your options and decide on what plan is best for you and your family. Below is a brief overview of the plans to help you make an educated decision.

- We will continue to offer three health plans: CDHP 1, CDHP 2, and the Traditional Plan.
- Deductibles and out-of-pocket maximums for all three plans will remain the same for 2025. The following chart illustrates the plan designs for 2025.

	CDHP 1			CDHP 2			Traditional		
	Tier 1 HealthSync	Tier 2 In-Network	Out of Network	Tier 1 HealthSync	Tier 2 In-Network	Out of Network	Tier 1 HealthSync	Tier 2 In-Network	Out of Network
Deductible									
Single	\$3,000	\$3,500	\$3,500	\$2,000	\$2,500	\$2,500	\$1,000	\$1,500	\$1,500
Family	\$6,000	\$7,000	\$7,000	\$4,000	\$5,000	\$5,000	\$2,000	\$3,000	\$3,000
Out-of-Pocket Maximum									
Single	\$4,500	\$5,000	\$5,000	\$3,500	\$4,000	\$4,000	\$2,500	\$3,000	\$3,000
Family	\$9,000	\$10,000	\$10,000	\$7,000	\$8,000	\$8,000	\$5,000	\$6,000	\$6,000

• The plans will continue to be tiered, with Anthem’s HealthSync as the Tier 1, lowest cost option. Within each plan, employees may choose providers from any of the network options. Each network has a diverse group of providers that provide all types of services including preventive care, acute care for illnesses, and chronic care. The big difference between the networks is the cost to you.

Tier 1 - HealthSync: Lowest Cost Option

To save the most money, use providers within the Tier 1 - HealthSync network. This tier has lower costs plus the lowest deductible, out-of-pocket maximum, and co-insurance rates. All in-network pharmacies through

the prescription drug coverage are Tier 1 providers.

Tier 2 - In-Network

Tier 2 is your next best option. This tier includes all other in-network providers. In-network providers have a contract with Anthem to provide services at a discount. They cannot bill members above that discounted rate.

Out-of-Network: Highest Cost Option

Out-of-network providers do not have an agreement with Anthem. Providers can charge you any amount for their services. The health plan will only cover the same cost as an in-network provider, and you will be balanced billed for any cost exceeding that amount.

You can use providers from all tiers at any time during the plan year. The amount you pay for each visit depends on the provider you chose for that visit. Each claim is applied to the deductible and out-of-pocket maximums of all tiers.

- The state’s Health Savings Account (HSA) contribution amount to each plan will be the same as 2024. Below is an overview of the most you will pay under each plan if you reach your out-of-pocket maximum. Please note the chart assumes you take advantage of the Non-Tobacco Use Incentive, only used Tier 1 providers, and are eligible for an HSA. Please view the [Maximum Exposure Chart](#) for additional scenarios.

With an HSA	Single			Family		
	CDHP 1	CDHP 2	Traditional	CDHP 1	CDHP 2	Traditional
Annual Employee Premium	\$859.56	\$1,237.08	\$2,756.52	\$2,608.32	\$3,995.16	\$9,466.08
Maximum Out-of-Pocket Cost	\$4,500	\$3,500	\$2,500	\$9,000	\$7,000	\$5,000
State Paid HSA Contribution	(\$1,124.76)	(\$787.80)	N/A	(\$2,249.52)	(\$1,575.60)	N/A
Total Exposure	\$4,234.80	\$3,949.28	\$5,256.52	\$9,358.80	\$9,419.56	\$14,466.08

R/x Coverage

Prescription drug coverage



CVS Caremark is the Pharmacy Benefit Manager (PBM) for the state. All three health plans have the same pharmacy benefit. In-network pharmacies are Tier 1 providers. Prescriptions filled at in-network pharmacies are considered Tier 1 expenses and will count toward both your Tier 1 and Tier 2 deductible and out-of-pocket maximum.

90-day fills can be made at your local retail pharmacy or through mail order. However, it is important to note that the co-pay and co-insurance amounts are a little higher on 90-day fills at the retail pharmacy than through the mail.

CVS Caremark Mail Service / Mail Order Pharmacy

Members that need medication on an ongoing basis can ask their doctor to prescribe up to a 90-day supply, plus refills if appropriate. Examples are ongoing therapies to treat diabetes, high cholesterol, high blood pressure, and asthma. Mail order offers the best value and has the following benefits:

- Medications are shipped with standard delivery at no additional cost.
- First-time orders are usually delivered within 10 days after the order is received.
- Refills usually arrive in less time – refills ordered online or via the CVS Caremark Mobile App are usually delivered within

three to five days and refill orders mailed in are usually delivered within six to nine days.

- Medication packages will include instructions for ordering refills, if applicable, and may also include information about the purpose of the medication, appropriate dosage guidelines, and other important details.
- You can track your prescriptions and order refills at www.caremark.com, via the CVS Caremark mobile app, or by calling 1-866-234-6869.
- Registered pharmacists are available around the clock for consultation.

Prescription Drug Coverage			
Deductible must be met before coinsurance rates apply			
	Retail Pharmacy Network (Up to 30 day supply)	Mail Service Pharmacy (Up to 90 day supply)	Retail Pharmacy Network (Up to 90 day supply)
Preventive Medicines (mandated by the ACA)	\$0 (no deductible)	\$0 (no deductible)	\$0 (no deductible)
Generic Medicines	\$10 co-pay	\$20 co-pay	\$30 co-pay
Preferred Brand-Name Medicines	20% Min. \$30, Max. \$50	20% Min. \$60, Max. \$100	20% Min. \$90, Max. \$150
Non-Preferred Brand-Name Medicines	40% Min. \$50, Max. \$70	40% Min. \$100, Max. \$140	40% Min. \$150, Max. \$210
Specialty Medicines	40% Min. \$75, Max. \$150 (30 day supply)		

Optum EAP

EAP benefits offer eight free face-to-face counseling sessions per issue and much 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. The [Optum Employee Assistance Program](#) (EAP) offers a wide variety of free services to you and your household members to help balance work and home life.

Full-time employees and their family members who reside in the household can connect with an Optum EAP consultant for online support at liveandworkwell.com (access code: Indiana), or by phone at 800-886-9747.

The Optum EAP is a free, confidential service to help you

and your family navigate life's challenges.

Optum's team of experienced consultants is available by phone or online 24/7 to provide help with a range of life concerns and stressors, including:

- Relationship problems.
- Workplace conflicts and changes.
- Parenting and family issues.
- Stress, anxiety and depression.
- Elder care support.
- Legal and financial concerns.

When you speak to a consultant, you'll receive immediate help or be directed to one of Optum's network providers. EAP provides up to eight (8) sessions with an experienced consultant for each issue or problem at no cost to



you, and the benefit renews each calendar year. All conversations are confidential, and they never share your personal records with your employer or anyone else without your permission.

Connect with Optum EAP



Call for personal support
800-886-9747



Log in to liveandworkwell.com for online support
Access code: Indiana



Connect through the Optum Assist app.
Log in to the app and enter access code: Indiana

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 a Health Maintenance Organization or Preferred Provider Organization) 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, visit: www.medicare.gov.

Anthem programs

Anthem supports your health goals



The state is committed to providing health plan members with helpful tools to achieve a more active and healthy lifestyle. All members enrolled in an Anthem plan receive special services at no additional cost.

Anthem 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, visit www.anthem.com, log in to your account, and select the "My Health Dashboard" tab on top of the page and then "Programs" from the drop-down menu.

In addition to the online tools, representatives may contact you directly as part of one of Anthem's programs. These programs include:

- Total Health, Total You:**
 Receive personalized support and care coordination following an illness or hospitalization. Case managers will explain your treatment options,

help you understand your health plan, connect you with local resources, and guide you toward healthy lifestyle changes.

- Building Healthy Families:**
 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 888-279-5449.

Anthem Programs

LiveHealth Online: See a doctor 24/7

It's easier and faster than going to urgent care. The next time you or someone in your family needs to see a doctor, use LiveHealth Online. See a doctor with a smartphone or tablet using the free app, or a computer with a webcam.

With LiveHealth Online, you get:

- Immediate, 24/7 access to board-certified doctors.
- Secure and private video chats with your choice of doctor.
- Prescriptions that can be sent to your pharmacy, if needed.

Doctors on LiveHealth Online are available to diagnose and treat a wide variety of medical care

needs. See a doctor for these medical conditions/services and more: flu, cold & fever, psychology, minor rashes, sore throat, psychiatry, tooth pain, skin infections, allergy, pink-eye, headache, and diarrhea.

The average cost of a doctor visit using LiveHealth Online is \$59.

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



LiveHealth[®]
O N L I N E

Anthem programs

Health plan questions?

Have you ever had a health question regarding an insurance claim or needed help finding a provider? Anthem has you covered with helpful, knowledgeable staff. All you need to do is pick up the phone or log into their app. Below is an overview of the resources available to you.

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:

YOUR ANTHEM HEALTH GUIDE IS HERE

Download the Sydney App today!

Learn more



Call your Guide:
(877) 814-9709

Anthem

- 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 App

Another great tool is the Sydney Health app. Sydney Health is your own personal



health assistant and benefits guide all rolled into one. Download the app to get started.

Log in using your Anthem username 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).

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.

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 recordings are available 24/7 by phone.

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

Vision

Vision plan

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.

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.

Fixed Copay

Fixed copays for premium progressive and anti-reflective lenses 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 contacts, please follow the below steps.

- Go to www.Anthem.com and log in to your account.
- Place cursor over the “My Plans” drop-down menu on top of the page.
- Select “Vision Benefits.”
- Select the “View your vision benefit information” link.
- To view a dependent’s service eligibility, select the member on the drop-down menu.

- Select dependent, then “submit.”

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, go to www.Anthem.com and log in to your account. Then click the “Find Care & Cost” link on the right side of the page. Add your address or zip code and search for “optometrist.” Scroll and filter for “Plan Network” on the left side. Select “Vision Network.”

More information about vision coverage can be found at www.in.gov/spd/openenrollment/vision.

Dental

Dental plan: In-network preventive services are 100% covered

Good dental health may be more important than you think. 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, click on the “Find Care & Cost” link on the right side of the page. Add your address or zip code and search for “dentist.” Scroll down and filter for “Plan Network” on the left side. Select “Dental Network”. To search without logging into your account, see the [Anthem How to Find Care - Dental Complete Flyer](#).

More information about the dental coverage can be found at: www.in.gov/spd/openenrollment/dental.

Know before you go

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? By choosing options other than the ER, your bill can be much lower and result in lower premiums for all employees.

When seeking medical care, it is important that you consider

all your options. However, it's important to remember that 911 is your best resource for any potentially life-threatening emergency. Don't hesitate to call if you have concerning symptoms such as difficulty breathing or signs of a heart attack (chest pain or numbness, pain in arms, etc.).

Below is a quick look at the cost difference among alternative treatment facilities and examples of when to go to each.

Every time you need care:



STOP



Review options



Save money

Where Should You Go to Get Care?

Visit Type	Cost	Pros & Cons	Examples of When to Go
Emergency Room	\$\$\$\$\$	Doesn't require an appointment & has access to the most care resources.	Stroke, heart attack/chest pain, severe burns, difficulty breathing, uncontrolled bleeding, head injuries, etc.
Urgent Care	\$\$\$	Typically no need for an appointment & often faster than ER visits.	UTI, ear/eye infections, sprains and strains, vomiting or diarrhea, sore throat, stitches.
Primary Care Provider	\$\$	Can take longer for an appointment but familiar with your health history.	Allergies, UTI, eye infection, sinus infection, rash, mild asthma, flu-like symptoms, aches/pains (not severe), routine care like vaccines.
Retail Health Clinic	\$\$	Ease of access but lacks health history that your PCP has & fewer care resources.	UTI, sore throat, STI testing, minor cuts and scrapes, ear pain, routine care like vaccines.
LiveHealth Online	\$	Ease of access but may need to seek follow up care for labs/other services.	Allergies, eye infection, sinus infection, UTI, rash, flu-like symptoms.
NurseLine	Free for members of Anthem Plan	Ease of access but may need follow up care for labs/other services.	Headaches, ear pain, allergies, questions regarding prescriptions, vaccines or more general health concerns.

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.

Health Savings Account (HSA)

State to contribute to Health Savings Account

The state will continue to contribute the same amounts to your HSA in 2025. The initial contribution will be made on your January 15, 2025 paycheck. Employees enrolled in a CDHP effective from January 1, 2025, through June 1, 2025, receive the full pre-fund amount. CDHPs effective after June 1, 2025, but before December 1, 2025, 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, 2025, or your first day of coverage in a state health plan during 2025.

If you have an active HSA with UMB and wish to continue receiving the state’s contributions in 2025, you do not need to open a new HSA account. Within PeopleSoft, Employee HSA contribution amounts do not carry over from year to year. If you would like to contribute to your account during 2025, you need to access your PeopleSoft record and

Plan	Initial Contribution	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

enter your desired contribution. If you are electing to participate in an HSA for the first time in 2025, you must select and elect the HSA option in PeopleSoft. UMB will automatically create your HSA account. You should receive the Welcome Letter prior to January 1. The Welcome Letter will contain your account number and information for enrolling in **UMB HSA Online Banking**. An HSA debit card will arrive in a separate mailing approximately 7-10 business days after your account has been opened.

If additional information is required to open an HSA, a Request for Information Letter will be mailed. Please reply in a timely manner so the account can be opened quickly.

Resources for you:

- [Top Questions about Health Savings Accounts](#)
- [Saving and Spending Health Savings Account Dollars](#)
- [Healthy Retirement Plans Include an HSA](#)
- [Pay for Qualified Medical Expenses Tax-Free](#)

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).
- Can’t be claimed as a dependent on another person’s tax return.
- May not be enrolled in Medicare, Medicaid, HIP or Tricare.

View [IRS Publication 969](#) for more information.

HSAs have a maximum contribution limit

Contributions are allowed up to the maximum statutory limit. The maximum annual contribution for 2025 is \$4,300 for self-only policies and \$8,550 for family policies.

Individuals age 55 and over may make an additional catch-up contribution of up to \$1,000 in 2025.

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	\$4,300	\$1,124.76	\$3,175.24	\$122.12	\$4,175.24	\$160.59
	Family	\$8,550	\$2,249.52	\$6,300.48	\$242.33	\$7,300.48	\$280.79
HSA 2	Single	\$4,300	\$787.80	\$3,512.20	\$135.08	\$4,512.20	\$173.55
	Family	\$8,550	\$1,575.60	\$6,974.40	\$268.25	\$7,974.40	\$306.71

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 following 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, they are not eligible to contribute to an HSA in their name, regardless of whether or not they are 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) 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.

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 Benefit Reimbursement Account may be for you. Through the Commuter Benefit 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 \$280.

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 if 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 to be reimbursed.

Eligible expenses are those you incur to commute to and from your place of employment. This includes

(Continued on pg. 13)

Continued: Commuter Benefit Reimbursement Account

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 2024 will carry over to 2025 unless you waive your coverage.

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

Flexible Spending Accounts

Medical and Limited Purpose Contribution Limit increasing for 2025

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 2025 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 an FSA for the 2025 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, 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 2024 account, you may continue to submit claims for reimbursed 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 2025, the annual contribution limit for the Medical Care and Limited Purpose FSAs will be increased to \$3,200.

A Limited Purpose FSA may only be used for dental, vision, and preventive care expenses until the minimum deductible of a CDHP is met (\$1,650 for single and \$3,300 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. A qualifying individual is your dependent who is under the age of 13 (when services are incurred) or your spouse or an older dependent who is mentally or physically incapable of self care who lives in your home at least 8 hours each day. 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).

For questions about flexible spending accounts, contact the Indiana State Personnel Department's Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007.

You may also contact ASIFlex customer service by phone at 800-659-3035, Mon. - Fri., 8 a.m. to 8 p.m. ET and Sat. 10 a.m. to 2 p.m. ET, or by email at asi@asiflex.com.

Non-Tobacco Use Incentive

Non-Tobacco Use Incentive

The Non-Tobacco Use Incentive (NTUA) is being offered for the 2025 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 2025. 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.

[Visit the FDA's website](#) for more info on FDA approved nicotine replacement therapy options.

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 2025. 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 Non-Tobacco Use Agreement (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 your receipts for these products and/or copies of prescriptions from your physician to demonstrate your compliance with the NTUA.

Please note, your non-tobacco use agreement will roll over.

However, open enrollment is your opportunity to review the agreement and decide if you need to change your agreement status. If you accept or continue to accept the agreement, you are agreeing to all the conditions to the non-tobacco agreement for the 2025 plan year. The incentive is available only to state employees who have enrolled in medical coverage. If you waive your non-tobacco agreement without waiving your medical plan, you will receive an enrollment error. **You must either accept or decline the non-tobacco use agreement to enroll in a medical plan for 2025.**

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.

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. For more information on WHCRA benefits, contact Anthem at 1-877-814-9709.

Open Enrollment Verification

How to verify your Open Enrollment submission in PeopleSoft

Every Open Enrollment, the Benefits Hotline receives an influx of calls towards the end of Open Enrollment with employees inquiring if their elections have been successfully submitted. To save you time and stress, below is an overview of how you can verify if your elections were submitted in PeopleSoft.

Verification of Submission

1. **Navigate** to **Employee Self Service** from the homepage.
2. **Select** the **Open Enrollment** tile.
3. **Select** the **Benefit Enrollment** tab on the left side of the page.
4. If the **Status** under the **Enrollment Summary** shows “**Submitted**,” your elections have been saved.
5. **Navigate** to the **Benefit Statement** tab to **print** your **Elections Preview**.

If the **Status** under the **Enrollment Summary** shows “**Changes saved – Submit to view**,” you need to **select** the **Submit Enrollment** button as you have made changes since the last time you submitted your enrollment.

- Once you **select** the **Submit**

Enrollment button, the **Status** will change to “**Submitted**.”

- **Navigate** to the **Benefit Statement** tab to **print** your new **Elections Preview**.

If the **Status** under the **Enrollment Summary** shows “**Pending Review**,” you need to **select** the **Submit Enrollment** button to submit your elections.

- Once you **select** the **Submit Enrollment** button, the **Status** will change to “**Submitted**”.
- **Navigate** to the **Benefit Statement** tab to **print** your new **Elections Preview**.

Potential Errors

If the **Submit Enrollment** button is grayed out there is an error in your enrollment that needs to be corrected.

- **Review** the benefit tile(s) under the **Benefit Enrollment** page to identify any tile(s) that show “**Error**” for the Status.
- **Select** the tile with the “**Error**” Status.
- **Read** the error message on the top of the page and **correct** the

corresponding issue.

- Once corrected, **select** the **Submit Enrollment** button, and the **Status** will change to “**Submitted**.”
- **Navigate** to the **Benefit Statement** tab to **print** your new **Elections Preview**.

If the **Benefits Alerts** pop up contains any warnings, there is an error in your enrollment that needs to be corrected.

- **Review** the warning. Then select the Done button.
- **Correct** the error associated with the warning message.
- Once corrected, **select** the **Submit Enrollment** button the **Status** will change to “**Submitted**.”
- **Navigate** to the **Benefit Statement** tab to **print** your new **Elections Preview**.

If you need additional assistance with completing your Open Enrollment please review the [Open Enrollment Quick-Step Guide](#) or call the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007.

Completing your Open Enrollment

You can access your Open Enrollment event 24 hours a day, seven days per week from Wednesday, October 30 through Wednesday, November 20 at noon (ET). You can access your Open Enrollment event from any computer that allows you access to

the internet. As a reminder, to sign into PeopleSoft, you must have [Multifactor Authentication \(MFA\)](#) set-up.

Quick Step Guide

- [2025 Open Enrollment Quick Step Guide](#)

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

Life Insurance

Life insurance

Life election changes within Open Enrollment event

Planning for the future can sometimes be overwhelming, but life insurance doesn't have to be. Within your open enrollment event, you can make many changes to your plans without going through underwriting. These include:

- Electing Voluntary AD&D and Child Only Dependent Life insurance (if you are currently enrolled in Basic Life and AD&D insurance).
 - Child Only Dependent Life insurance may be elected in increments of \$5,000 up to and including \$20,000 for your children.
- Decreasing your coverage level or dropping any of your life insurance plans.
- Updating your beneficiary information and/or allocation amounts.

New Supplemental Life options with Evidence of Insurability (EOI)

For 2025, the maximum amount of Supplemental Life coverage is increasing from \$500,000 to \$750,000. To apply, please complete the online Evidence of Insurability (EOI) process at www.lifeBenefits.com/SubmitEOI.

You may request any amount in increments of \$10,000 up to \$750,000, if you are enrolled in Basic Life insurance. Premiums are based on the amount of coverage and your age.

Please note, individuals age 65 and older are limited to \$200,000 or less of Supplemental Life coverage. If approved, the Indiana State

Any updates you make to your life insurance within your open enrollment event will be effective January 1, 2025.

Life election changes outside of Open Enrollment event

If you wish to elect or increase your Basic Life and AD&D, Supplemental Life or Spouse Dependent Life coverage, all you need to do is complete the online Evidence of Insurability (EOI) process at www.lifeBenefits.com/SubmitEOI. On average, the application only takes 10 to 30 minutes to complete. Once you submit your application, Securian will review your information through underwriting and if approved, State Personnel Benefits will automatically enroll you in the requested coverage.

For more information about your life insurance options, please visit www.in.gov/spd/openenrollment/life-insurance.

Personnel Department Benefits Division will automatically enroll you in the requested coverage.

Take the time during open enrollment to review your finances and consider which option and coverage amount is best for you and your family. If you need help figuring out how much life insurance is right for you, try walking through [Benefit Scout](#) to find the recommended amount.

Additional information about coverage and rates:

- [2025 Life Insurance Plan Summary](#)

Review & update your life insurance beneficiary info

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 beneficiaries. Under the Indiana State Personnel Department's policy, we will not share coverage amounts or beneficiary information with 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 1, 2025.

Short and Long-Term Disability

State of Indiana Short and Long-Term Disability eligibility changes

The Indiana State Personnel Department (INSPD) has revised the [State of Indiana Short and Long-Term Disability and Worker's Compensation Programs Employee Handbook](#) to adhere to recent administrative rule changes. Please note the following changes:

- Effective January 1, 2025, the new rules will be applied to the eligibility criteria to specify that an employee must be employed on a full-time basis for at least six (6) months of continuous full-time employment.
- A break in service due to resignation, retirement, layoff, termination, or an unauthorized leave of absence (unauthorized leave of 3 or more days) will cause the six months of employment to restart from the day they return to work.
- An authorized leave of absence without pay is not considered a break in service but is not counted toward the six months of active work requirement so that the length of authorized leave without pay is added to the period before the employee becomes eligible. Any day with more than 4 hours of authorized leave time is counted as a full day.
- An unauthorized leave of absence without pay of less than 3 days will not be considered a break in service, but the time will be added to the six-month required working period before the employee becomes eligible.
- For the purpose of calculating the benefit amount when an employee is disabled by injuries resulting from the tortious act of another person, a correctional officer's base biweekly wage is determined using the number of hours the officer is typically scheduled to work during a pay period, excluding premium overtime.

New employees will receive an email from the INSPD Benefits Division when they first become eligible for disability benefits, letting them know that premiums will start being deducted. If there is a situation where a future disability eligibility date needs to be confirmed, please call the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007, and they can review and advise as needed.

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 Anthem toll-free at 1-877-814-9709.

Wellness Rewards Program

There's still time to earn Wellness Rewards



Wellness Rewards Program

Get Rewarded for What Matters

Eligible employees and spouses can still earn up to \$500 in Wellness Rewards, but time is running short. All gift cards must be earned and redeemed by December 31, 2024. Below are some of the activities you still have time to complete:

\$25 for completing a Health Assessment

Get an overview of your current health and identify areas for improvement.

\$25 for receiving each rewardable vaccine (up to \$100)

COVID-19, flu, hepatitis A and B, HPV, measles, mumps and rubella (MMR), meningitis, pneumonia, chickenpox, shingles, diphtheria, tetanus, pertussis (whooping cough), and respiratory syncytial virus (RSV) are all rewardable vaccines in 2024. Check with your primary care provider to see which vaccines are right for you and [click here to see current vaccine clinics](#). Flu and COVID-19 vaccines are also available at local pharmacies without a prescription.

\$20 for completing each Individual Health Coaching session (up to \$100)

Get expert help to make healthy changes in exercise, diet, sleep, mindfulness, work-life balance, tobacco cessation, weight management, or other areas you want to focus on. Call (855) 202-4219 to schedule an appointment. Health coaches are available from 9 a.m. to 9 p.m. ET Monday through Friday and from 9 a.m. to 2 p.m. Saturdays by appointment.

\$10 for completing a 5K, exercise class, or sports league

Complete a race (like a 5K or marathon), take an exercise class, or participate in a sports league and then verify your activity and completion date in the ActiveHealth portal.

\$5 for participating in a Wellness Learning Activity (up to \$10)

Attend a Wellness Learning Activity like "Resilience, bouncing back from stress" on November 1 and 15. Find a full list of times [here](#).

\$15 for completing each session with Anthem's Building Healthy Families Program (up to \$45)

Work with Anthem's Building Healthy Families Program during your pregnancy to earn up to \$45 in rewards. Connect with this program through [Anthem.com](#) or your Sydney app.

\$10 for each day you complete an assessment with Anthem's Total Health, Total You (up to \$50)

Anthem gives you access to a team of clinicians to help you navigate any healthcare need. Your Total Health Total You team is here to

help explain treatment options, understand your care plan, connect with local resources, and guide you toward healthy lifestyle changes. Connect with this program by calling Anthem at 877-814-9709.

And if you need a refresher on how to redeem your rewards, please follow these steps:

1. [Log in to the ActiveHealth portal](#) using your username and password. Once you are logged in, you can navigate to the "Rewards Center" by clicking on the "Rewards" tab in the top menu.
2. In the rewards center you can see how much you have earned so far. You can redeem your rewards in increments of \$50 by clicking on "Redeem My Rewards" underneath your progress bar.
3. Select the amount you would like to claim and which vendor you would like to redeem the card through and then follow the prompts to confirm your selection.

We know that life can be busy, but taking care of your health is important for both you and your family. By completing these activities, you are investing in what matters, your health and wellbeing.

What are you waiting for? [Log in](#), claim your rewards, and check out other ways to improve your health & continue earning rewards today!

[Log in to ActiveHealth](#)

Annual Physical

Don't forget to get your annual physical

2024 WELLNESS REWARDS PROGRAM

Earn \$200 for completing an annual physical.

Learn more



Invest In Your Health Wellness Rewards Program
Get Rewarded for What Matters

There's still time to complete your annual physical! Not only can a physical earn you [\\$200 in Wellness Rewards](#), but it's also an opportunity to measure blood pressure, cholesterol, glucose levels, and more to make sure you're in good health. It is easy to get in the mindset that you don't need a physical if you don't feel sick. However, getting your recommended preventive care screenings like an annual physical is the best way to monitor your health and catch problems early — **and may even save your life.**

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 can 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 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.

Tips for finding a PCP

If you don't have a Primary Care Provider (PCP), pick one today!

- Start by looking for in-network providers through the [Anthem website](#) or [Anthem Sydney app](#).
- Look for Tier 1 Health Sync providers for the most affordable care option.
- Check out the provider's background and training to make sure they're a good fit for your health needs.
- Ask which options the provider offers to receive care in addition to office appointments such as

virtual visits, emailing, texting & calling for advice on concerns.

- Check if the provider offers meet-and-greet appointments to see if it is a good fit before you are seen for medical care.

How to earn your Annual Physical wellness reward

1. Schedule an appointment for your physical with lab work.
2. Print the [Annual Physical Results form](#) and fill in Section 1. Bring the form to your appointment and have your doctor complete Section 2.
3. Follow instructions on the form to submit it via fax or upload. You will receive a confirmation email within two business days of your form being received. **Please note, it can take up to 4 weeks for forms to be processed.**

Results must be visible in the [ActiveHealth portal](#) by December 31, 2024, to receive the wellness reward.

The health plan pays for one physical every calendar year. You don't have to wait 365 days from your last physical. Schedule your physical today!

Invest In Your Health Wellness Program

Benefits to support your life

Life is full of moments that require assistance with a specific need, whether it's health-focused or related to your family or finances. That's why, in addition to our core benefits (medical, dental, vision), the State of Indiana offers a variety of benefits to help you navigate instances when you need extra support with your physical, mental, social, and financial health.



Tailored Support for Prediabetes & Diabetes

Managing prediabetes and risk factors associated with diabetes can be challenging, which is why we offer several programs to help.

- ▶ **Community Diabetes Prevention Programs:** In-person programs to help develop and maintain healthy lifestyle changes that can prevent or delay the onset of diabetes.
Cost: Many are free, some may be self-pay only.
[Get started >](#)
- ▶ **LiveHealth Online Prevent Diabetes:** Virtual support to delay or prevent the onset of diabetes.
Cost: Free
[Get started >](#)
- ▶ **Lark Diabetes Prevention Program:** Fully digital, app-based support

to prevent or delay the onset of diabetes.

Cost: Free

Helps with: losing weight, eating healthier, increasing activity, sleeping better, managing stress.

[Get started >](#)

- ▶ **9amHealth Diabetes Management Program:** Diabetes management program provides easy access to specialists and dieticians.

Who can use: Health plan members (18+) who are diagnosed with diabetes.

Cost: Free app, coaching, and devices with supplies. Virtual doctor visits, lab tests, and medications subject to deductible.

What: Unlimited fitness and nutrition coaching. App to see glucose trends.

[Get started >](#)



Support When Life is Challenging

Perhaps you're dealing with challenging relationships, job struggles, family conflict, or another difficult situation. If you need help coping with life's challenges, help is available, and many of these programs are provided at no cost to you.

- ▶ **Optum EAP, our Employee Assistance Program:** Free and confidential counseling (virtual and in-person) with licensed therapists.
Who can use: Full-time employees and household members.
Get help with: Alcohol and drug misuse, anxiety, sadness or depression, grief and loss, family and parenting issues, life changes and personal crises, stress due to work, or personal issues.
Get started: liveandworkwell.com or 800-886-9747.
- ▶ **TalkSpace:** In-network provider with Optum EAP that offers an app that connects you with mental health providers through virtual sessions.
How it works: Get your TalkSpace authorization code through Optum EAP. Download the TalkSpace app. Start therapy within hours of choosing your therapist. Schedule an appointment for a face-to-face, virtual visit.
Get started: 800-886-9747 for authorization code, then download the app.
- ▶ **Need help finding a counselor?** Optum's Assisted Search does the research for you, saving you time and legwork. Optum identifies which providers are accepting new patients and have availability that meets your needs. Call 800-886-9747 for this FREE service.
- ▶ **LiveHealth Online:** Virtual access to psychiatrists who can prescribe medications, as well as to licensed therapists for counseling sessions.
Who can use: Health plan members.
Get started: livehealthonline.com or Sydney Health mobile app.
- ▶ **Learn to Live:** Personalized coaching experience that offers

(Continued on pg. 21)

Continued: Benefits to support your life

behavioral health strategies, referrals to local and online resources, and encouragement as you work toward your goals.

Who can use: Health plan members.

What: Wellness coaching, mindfulness tools and resources, live and on-demand webinars, Spanish-speaking coaches available.

Get started: [anthem.com](https://www.anthem.com) > My Health Dashboard > Programs > Emotional Well-being Resources.



Advantages of a Second Opinion

Receiving a medical diagnosis and making treatment decisions can be a lot to take in. Sometimes, you may want to pause and get a second opinion. Anthem's partnership with the Cleveland Clinic makes that possible.

Virtual Complimentary Clinical Review

Review: Review from a top-ranked specialist at Cleveland Clinic.

Who can use: Health plan members.

Cost: Free

How it works: Schedule a virtual appointment with a referral team member > have your case assigned to the right specialty doctor > receive the recommended treatment plan within five days.

Get started: 833-355-0454 or anthemreferral@ccf.org.

Go-To Source for Orthopedic Care

In need of orthopedic care due to a broken bone, back pain, or ACL

tear? You're in luck. OrthoIndy, an Anthem Tier 1 provider, is the State's preferred orthopedic provider.

► **OrthoIndy:** Preferred orthopedic provider for State employees. The practice is ranked #1 in Indiana for total joint replacement, and as a Tier 1 provider, it offers lower costs for surgeries and other orthopedic services.

What: Walk-in urgent care, surgical and non-surgical consultations, physical therapy, imaging.

Get started >

Note: If you have to travel more than 50 miles for inpatient or outpatient care at OrthoIndy, the State offers a travel benefit to help pay for ground transportation and lodging. You must get prior approval for the assistance.



Kick the Tobacco Habit

Nicotine is addictive, and that makes kicking the tobacco habit hard. We've partnered with ActiveHealth to provide health plan members a coaching program proven to work.

► **Commit to Quit:** Six-week program with personalized, one-on-one coaching.

Who can use: Health plan members.

Bonus: \$100 in Wellness Rewards by completing the program.

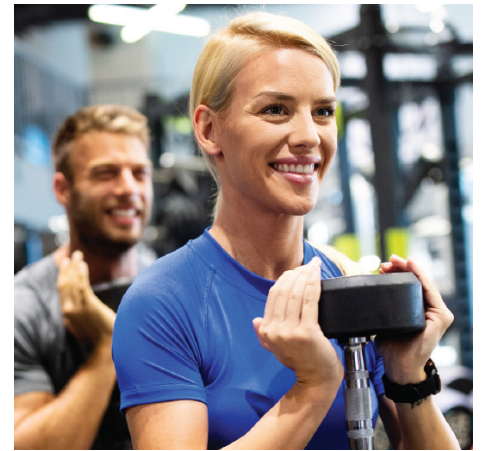
Get started: myactivehealth.com/stateofindiana or 855-202-4219.

► **Nicotine Replacement Therapy (NRT):** \$0 cost tobacco cessation

medications. [View covered products.](#)

Who can use: Health plan members.

Get started: Verify coverage at 866-234-6869 or [caremark.com](https://www.caremark.com).



Access Valuable Discounts

Life can be expensive, whether it's staying healthy, buying computers or phones for your family, traveling, or a host of other expenses. Thanks to our partnerships, we're able to offer employees exclusive discounts.

► Gym & Fitness Center Discounts

Who can use: Employees and family members.

Get started >

► Hearing Aid Devices

Who can use: Employees and family members.

Manufacturers: GN Resound, Sonova (Phonak & Unitron), Oticon, Signia, Starkey, Widex.

Get started >

► Additional employee discounts:

Discounts for cars, banking, phones, entertainment, health, and more!

Get started >

Plus, Anthem offers discounts at [anthem.com](https://www.anthem.com) > Care > Discounts.

Learn More

Dependent Eligibility

Children 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 must 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, 2025.

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, 2025.

Outside of Open Enrollment, you may only add a disabled dependent through a qualifying event. Like 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: 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 31 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 (ET) on Wednesday, Nov. 20, 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 (health, vision, and dental). After Open Enrollment, you can only make changes in conjunction with a qualifying event.

Qualifying events are regulated and defined by the IRS, including:

- Changes in your legal marital

status (marriage, divorce, separation, annulment, or death of spouse).

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

attainment of limiting age).

If you do not report a qualifying event and complete any necessary paperwork within 30 calendar days from the date of the qualifying event, you 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.**

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.

"Dependent" means:

- (a) The 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:
 - i) for whom the employee or spouse has been:
 - I) appointed legal guardian or
 - II) awarded legal custody by a court, or
 - ii) in an I.C. 31-19-7-1 approved placement for purposes of adoption, under the age of twenty-six (26).

In the event a child:

- i.) was defined as a "dependent", prior to age nineteen (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 Contractor in accordance with Contractor's disabled dependent certification and recertification

procedures. Eligibility for coverage of the "Dependent" will continue until the employee discontinues his coverage or the disability no longer exists. A Dependent child of the employee who attained age 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 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 call the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007. **To be eligible to enroll your dependent(s) as part of your Open Enrollment event for an**

effective date of January 1, 2025, 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 health plan

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

Affordable Care Act

Reporting Social Security Numbers

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 five methods in which you may report this information to the Benefits Division.

- **Phone:** 317-232-1167 or 877-248-0007 (toll-free)
- **Fax:** 317-232-3011
- **Mail:** State Personnel Dept.
Attn: Benefits Division
402 W. Washington St., W161
Indianapolis, IN 46204-2261
- **Email:** SPDBenefits@spd.in.gov
Please send by encrypted email only.
- **PeopleSoft Self Service:**
[Visit the PeopleSoft HR portal](#)
> Log in using your unique user ID and password > Select the Nav Bar in the top right corner > Select Menu > Select Self Service from the drop-down menu > Select Benefits > Select Dependent/Beneficiary Info > Select the Name of

the individual to update > Click Edit > Enter the SSN > Click Save > Sign out of PeopleSoft

All names and Social Security numbers in PeopleSoft must match the information listed on you and your dependent's 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 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). Additional information can be found on the [IRS website](#).

Federal Notice

Newborns' & 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).

Federal Notices

The Federal Notices listed below can be found at www.in.gov/spd/openrollment/federal-notices.

- Women's Health and Cancer Rights Act of 1998
- HIPAA Special Enrollment Rights Notice
- Creditable Coverage Notice
- HIPAA Notice of Privacy Practices
- Notice Regarding Wellness Program
- Nondiscrimination Notice
- Newborns' & Mothers' Health Protection Act of 1996
- Medicaid and the Children's Health Insurance Program (CHIP)
- USERRA (Military Leave) Notice
- Your Rights and Protections Against Surprise Medical Bills