2016 BENEFITS

OPEN ENROLLMENT

OCT 28 - NOV 18, 2015

(BY NOON EST)

CALL THE BENEFITS HOTLINE WITH QUESTIONS
MONDAY – FRIDAY, 7:30AM – 5:00PM EST

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

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

Webinars will be available to learn more about your 2016 benefit options.

DEADLINE IS WEDNESDAY, NOV 18

@INSPDBenefits
www.IN.gov/SPD/openenrollment

Invest In Your Health

2016 Benefits Overview

Welcome to Open Enrollment for the 2016 benefit plan year. This is your annual opportunity to explore the many benefit options the State of Indiana has to offer and make changes to your coverage. I hope this open enrollment period raises your awareness of the options and tools you have at your disposal to improve your overall health and well-being. Many have already taken advantage of the wellness portal offered through HumanaVitality. We are so pleased and encouraged by this participation and the engagement in other Invest in Your Health sponsored programs during 2015! Your enthusiasm and feedback continues to motivate us to deliver a benefit design that helps you meet your personal health goals.

In 2016 our healthcare costs are expected to increase $15 million. A portion of this increase can be attributed to the Affordable Care Act (ACA), which adds more than $1 million of costs to our plan. More significantly, new specialty drugs that offer real solutions to some of our members come with much higher costs, approximately $3M for 2016. The state will once again contribute 50 percent of the increase in plan costs, or $7.5 million. Thankfully, the hard work that our employees are putting in to improve their health through the state's wellness initiative and seeking the most efficient care possible has helped slow the rate at which our costs are increasing.

This past year we introduced the HumanaVitality, a wellness portal which enables employees to improve their overall wellbeing by understanding their current wellbeing level, setting goals and tracking their progress on those goals. More than 6,400 employees took advantage of this tool and attained Silver Status in HumanaVitality by August 31, which qualifies them to enroll in the Wellness CDHP. The Wellness CDHP upgrade offers participants savings over the CDHP 1 and 2 plans and offers higher HSA contributions. Wellness CDHP qualifiers have earned $934 in premium savings and an additional $500 in HSA contributions for those with family coverage. All Silver Status achievers were notified by letter the week of September 20th about their ability to select the Wellness CDHP Plan. While the savings in both bi-weekly premiums and additional HSA contributions are meaningful, even more so are the participants' positive changes in lifestyle and greater awareness of their health risks.

Another valuable Invest in Your Health tool is Castlight. Castlight, our

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This booklet is prepared each year by the Indiana State Personnel Department as a helpful reference for state employee health benefits.

Open Enrollment is Wednesday, Oct. 28 to Wednesday, Nov. 18, 2015. The Open Enrollment website is live at www.in.gov/spd/openenrollment.

Benefits information for current year can always be found online at www.in.gov/spd/2737.htm.

2016 Benefits Overview (Continued from page

cost and quality transparency portal, enables our members to be better informed consumers. State employees have saved more than $500,000 using Castlight in the last year and are more aware of their care by having access to current deductible spending incurred during the benefit plan year and medical claims. Making good consumer choices means better health outcomes and lower costs for you.

As you start considering your enrollment options for 2016, the amount of information can be overwhelming. To ease understanding, here are three simple steps you can take now to evaluate the best options for you and your family in 2016:

1. Visit www.in.gov/spd/openenrollment to review your plan options.
2. Visit www.InvestInYourHealthIndiana.com to see all of the resources the State of Indiana offers you to be proactive in managing your health. This includes a "Checklist as You Go" template to guide you through a successful 2016 Open Enrollment.
3. Ensure you are getting all the information SPD provides to make your open enrollment successful. Ensure your personal information is updated in PeopleSoft, sign up your personal email (or your dependents' email) to receive our employee benefits updates and follow our @INSPDBenefits Twitter feed to obtain the latest and greatest health plan updates.

Open enrollment begins Wednesday, October 28 and ends at noon (EST), Wednesday, November 18, 2015.

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

The highlights of the 2016 benefits include:

- Four healthcare plans (three CDHPs and one Traditional PPO)
- Out-of-Pocket-Limits (OOPM) are REDUCED in the CDHP1 and Wellness CDHP Plans for individual limits (stay tuned for important communications on this change)
- Non-tobacco use incentive remains at $35 per pay period
- The Medical Flexible Spending Account contribution limit remains at $2,500
- Those who qualify for the Wellness CDHP, the state will contribute approximately 50 percent of the deductible into an HSA on an annual basis.
    - HSA — $1,251.12 (single); $2,502.24 (family)
- For CDHP 1 and CDHP 2 participants with an HSA, the state will contribute nearly 40 percent of the deductible on an annual basis.
    - HSA1 — $1,001.52 (single); $2,003.04 (family)
    - HSA2 — $599.04 (single); $1,198.08 (family)

2016 BENEFITS OPEN ENROLLMENT

Check the list as you go

- [ ] Educate yourself about changes occurring Jan. 1, 2016.
- [ ] Access your PeopleSoft account.
- [ ] Confirm or update your personal information including your home and/or mailing address, phone number and ethnic group.
- [ ] If you wish to drop your insurance coverage you will need to select waive.
- [ ] If you are eligible for the 2016 Wellness CDHP, you will need to select this option to enroll in the plan if you were not covered under the 2015 Wellness CDHP.
- [ ] If you were enrolled in the 2015 Wellness CDHP, but do not qualify for the 2016 Wellness CDHP your plan will default to CDHP 1 unless you make a new selection.
- [ ] Review your eligible dependents and beneficiaries.
    - You will need to enroll all eligible dependents in each benefit plan you choose.
    - Make sure you remove ineligible dependents from all of your benefit plans.
    - Update personal information for each dependent and/or beneficiary.
        - Add your dependent social security numbers.
        - For dependent/beneficiary name changes, please contact the Benefits Hotline at 317-232-1167 or toll free at 877-248-0007 (if outside of the Indianapolis area).
- [ ] 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, you will need to enter your annual contribution amount.
- [ ] If you have a Flexible Spending Account, you will need to re-elect or re-state your annual contribution amount.
- [ ] Accept or decline the Non-Tobacco Use Agreement for 2016.
- [ ] Be sure to print an Election Summary after you have submitted your elections.

Maximum personal costs calculations*

Single Coverage	Wellness CDHP	CDHP1	CDHP2	Traditional PPO
Premium	$369.72	$686.40	$2,669.16	$7,619.04
Maximum out-of-pocket	$4,000.00	$4,000.00	$3,000.00	$3,000.00
State's HSA contribution	($1,251.12)	($1,001.52)	($599.04)	(0)
Total maximum personal cost	**$3,118.60**	**$3,684.88**	**$5,070.12**	**$10,619.04**
Family Coverage	**Wellness CDHP**	**CDHP1**	**CDHP2**	**Traditional PPO**
Premium	$1,180.92	$2,115.36	$7,762.56	$21,751.08
Maximum out-of-pocket	$8,000.00	$8,000.00	$6,000.00	$6,000.00
State's HSA contribution	($2,502.24)	($2,003.04)	($1,198.08)	(0)
Total maximum personal cost	**$6,678.68**	**$8,112.32**	**$12,564.48**	**$27,751.08**

*Examples assume employee is participating in the non-tobacco use incentive, using in-network providers and has an open HSA account. These comparisons represent the worst case scenario, which would include the premium costs, deductible and maximum out-of-pocket expenses for 2015.

What is next?

Start now, before open enrollment launches, to learn all you can about the options and your needs.

1. Review your health expenses from this year and begin projecting next year's expenses. Log onto www.anthem.com and review your up-to-date medical claims. If you have not registered with Anthem online, you must do that before you have access. Participants can also log on to Castlight to view a summary of year-to-date spending.
2. Log onto Express Script's website and look at your pharmaceutical claims (www.expressscripts.com). From there, you have a fairly good idea of what your expenses have been and should be able to make an estimate for 2016.
3. Read and analyze all the information available to you and attend webinars, carrier fairs, and information sessions – in order to become a well-informed healthcare consumer. If you plan to take advantage of the meetings or webinars, make sure you first get your supervisor's approval. These events are usually allowed on state time.
4. Ask questions if you don't understand. Call or email the Benefits Hotline to talk with a benefits specialist.

Questions?

SPD Benefits Hotline & Contact Information

More detailed information is available on the 2016 open enrollment website: www.in.gov/spd/openenrollment/

Or, contact the Benefits Hotline toll-free at 1-877-248-0007 outside of Indianapolis or 317-232-1167 within the Indianapolis area. Benefit specialists are available from 7:30 a.m. to 5 p.m. Monday through Friday, Eastern Standard Time.

You may also email your questions to SPDBenefits@spd.in.gov.

A guide to a successful Open Enrollment

Completing your Open Enrollment

You can access your Open Enrollment event 24 hours, seven days a week from Wednesday, Oct. 28 through noon Wednesday, Nov. 18 (EST). Keep in mind, you can access your Open Enrollment event from any computer that allows you access to PeopleSoft.

Helpful hints:

1. Your User ID is your 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 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, 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.
4. When making your elections in PeopleSoft, do not use the BACK/FORWARD arrow buttons at the top of your web browser.
5. Keep in mind you must turn off your "pop-up blocker" in order to print your Benefit Election Summary.
6. 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 that you submit your elections and print a Benefit Election Summary for your records.

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 below links:

- https://hr.gmis.in.gov/psp/hrprd/?cmd=login&languageCd=ENG&
- http://www.in.gov/spd and click on the PeopleSoft HR link on the right side
- http://myshare.in.gov/ and select the Oracle Human Resources link.

To view your current benefit elections, you need to login to PeopleSoft and follow these steps: Click on Self Service, Click on Benefits and Click on Benefit Summary. Your 2016 benefits will not be available to view until Jan. 1, 2016.

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 Indianapolis area or 1-877-248-0007 toll-free outside Indianapolis

2016 BENEFITS OPEN ENROLLMENT

When do my changes take effect?

Health, dental, vision, Health Savings Account and Flexible Spending Account change / enrollments are effective January 1, 2016.

Deductions for health, dental and vision begin:

- **Payroll A**: Dec. 16, 2015 (12 days at old plans & rates; 23 days for new plans & rates)
- **Payroll B:** Dec. 23, 2015 (5 days at old plans & rates; 9 days for new plans & rates)

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

- **Payroll A:** Jan. 13, 2016
- Payroll B: Jan. 6, 2016

Effective dates for Life insurance changes / enrollments vary depending on which payroll you are in along with the date your deductions begin.

- **Payroll A:**
  - Effective: Jan. 3, 2016
  - Deduction: Dec. 30, 2015
- **Payroll B:**
  - Effective: Jan. 10, 2016
  - Deduction: Jan. 6, 2016
- **Direct Bill:**
  - Effective: Jan. 1, 2016

Non-Tobacco Use Incentive

SAVE MONEY AND YOUR HEALTH BY GOING TOBACCO-FREE

For 2016, the state is again offering a $35 reduction in health plan premiums to each employee who agrees to not use tobacco during the year.

Non-tobacco use incentive

While you are completing open enrollment for your 2016 health benefits, you have the option to select the Non-Tobacco Use Agreement. If you select this, that means you will not use any tobacco products throughout 2016 and agree to nicotine testing. The testing is conducted at random, so there is no knowledge of when to expect the test.

To receive the $35 incentive, an employee must be tobacco-free by January 1, 2016, and continue so through the calendar year. If you currently use tobacco, but plan to quit and select the agreement, you would be wise to stop using tobacco now.

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

The agreement does not carry over, so if you want the 2016 incentive, you need to complete the Non-Tobacco Use Agreement during open enrollment. The incentive is available only to state employees who have enrolled in medical coverage.

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

2016 BENEFITS OPEN ENROLLMENT

Help sessions are available

Have questions? Need more help?

For 2016 plan summaries, rates, PeopleSoft instructions and other Open Enrollment information, please log onto www.in.gov/spd/openenrollment/. Help sessions are provided in the Indiana Government Center South Training Room 31 throughout Open Enrollment for those needing assistance with entering elections and navigating through PeopleSoft. Hours are (Eastern Standard Time):

- Oct. 28 to Nov 6: 8 a.m. to 3 p.m.
- Nov. 9 to Nov 13: 8 a.m. to 4 p.m.
- Nov. 16 to Nov. 17: 8 a.m. to 5 p.m.
- Wednesday, Nov. 18: 8 a.m. to noon

If you have specific questions about Open Enrollment not answered on the State Personnel Department's website, call or email a Benefits Specialist in State Personnel:

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

Summary of Plans and Rates

State offers four different options for single and family coverage

The state is offering four statewide plans: Wellness Consumer-Driven Health Plan (Wellness CDHP), Consumer-Driven Health Plan 1 (CDHP1), Consumer-Driven Health Plan 2 (CDHP2) and Traditional Preferred Provider Organization (PPO). All four available plans are in the Blue Access PPO network with Anthem and have a prescription drug plan through Express Scripts. Each plan has differences in premium costs, deductibles and out-of-pocket maximums. Please note in order to be eligible to enroll in the 2016 Wellness CDHP, you must have attained Silver Status in Humana Vitality by August 31, 2015.

One significant change in the plans for this year is the addition of an individual embedded out-of-pocket maximum for the family Wellness CDHP and CDHP 1. The individual embedded out-of-pocket maximum will save families money by limiting the cost spent on any one person to $6,850. Once a family member meets the individual embedded out-of-pocket maximum all claims incurred by that family member will be 100% paid by the plan. The other family members on the plan will continue to pay the coinsurance amounts for any claims they incur until the family out-of-pocket maximum of $8,000 is obtained.

All four plans offer 100 percent coverage on preventive services received in-network such as: annual physicals, well baby visits, mammograms, prostate exams, routine vaccines and annual pap smears. Premiums, co-insurance, out-of-pocket maximum expenditures and contributions to Health Savings Accounts (HSAs) are all part of the equation to make the best decision with your health care dollars. Please take advantage of all the information and resources available online to help you make the best decision for you and your family: www.in.gov/spd/openenrollment.

Please note that if you qualify for the Wellness CDHP and wish to enroll in the plan for 2016, you must select this option within your Open Enrollment event. You will not be automatically enrolled into the plan unless you were enrolled in the Wellness Plan for the 2015 plan year. If you were enrolled in the 2015 Wellness CDHP but do not qualify for the 2016 Wellness CDHP, your coverage will automatically be switched to the CDHP 1 unless you actively elect another plan.

Here are the differences at a glance:

Feature	Wellness CDHP	CDHP 1	CDHP 2	Traditional PPO
Deductibles				
Single	$2,500	$2,500	$1,500	$750 / $1,500
Family	$5,000	$5,000	$3,000	$1,500 / $3,000
Out-of-pocket maximum				
Single	$4,000	$4,000	$3,000	$3,000 / $6,000
Family	$8,000	$8,000	$6,000	$6,000 / $12,000
- Individual Embedded	$6,850	$6,850	Not applicable	Not applicable
Co-insurance				
In-Network	20%	20%	20%	30%
Out-of-Network	40%	40%	40%	50%

All three of the Consumer-Driven Health Plans (CDHPs) have the same prescription coverage while the Traditional PPO has slightly higher copays, coinsurance rates and min/max amounts.

Summary of Plans and Rates

State of Indiana 2016 Rates

Plan	Coverage	Bi-Weekly Employee Rate	Bi-Weekly Employer Rate	Bi-Weekly Total Rate	Early Retirees (Monthly)	COBRA (Monthly)	Annual Employee Rate	Annual Employer Rate	Annual Employer HSA Contribution	Total Annual Employer Contribution	Annual Total Rate
Wellness	Single	$49.22	$183.78	$233.00	$504.83	$514.93	$1,279.72	$4,778.28	$1,251.12	$6,029.40	$7,309.12
	Family	$80.42	$556.62	$637.04	$1,380.25	$1,407.86	$2,090.92	$14,472.12	$2,502.24	$16,974.36	$19,065.28
Wellness W/ Non-Tobacco Use	Single	$14.22	$183.78	$198.00	$429.00	$437.58	$369.72	$4,778.28	$1,251.12	$6,029.40	$6,399.12
	Family	$45.42	$556.62	$602.04	$1,304.42	$1,330.51	$1,180.92	$14,472.12	$2,502.24	$16,974.36	$18,155.28
CDHP 1	Single	$61.40	$193.38	$254.78	$552.02	$563.06	$1,596.40	$5,027.88	$1,001.52	$6,029.40	$7,625.80
	Family	$116.36	$575.82	$692.18	$1,499.72	$1,529.72	$3,025.36	$14,971.32	$2,003.04	$16,974.36	$19,999.72
CDHP 1 W/ Non-Tobacco Use	Single	$26.40	$193.38	$219.78	$476.19	$485.71	$686.40	$5,027.88	$1,001.52	$6,029.40	$6,715.80
	Family	$81.36	$575.82	$657.18	$1,423.89	$1,452.37	$2,115.36	$14,971.32	$2,003.04	$16,974.36	$19,089.72
CDHP2	Single	$137.66	$208.86	$346.52	$750.79	$765.81	$3,579.16	$5,430.36	$599.04	$6,029.40	$9,608.56
	Family	$333.56	$606.78	$940.34	$2,037.40	$2,078.15	$8,672.56	$15,776.28	$1,198.08	$16,974.36	$25,646.92
CDHP 2 W/ Non-Tobacco Use	Single	$102.66	$208.86	$311.52	$674.96	$688.46	$2,669.16	$5,430.36	$599.04	$6,029.40	$8,698.56
	Family	$298.56	$606.78	$905.34	$1,961.57	$2,000.80	$7,762.56	$15,776.28	$1,198.08	$16,974.36	$24,736.92
Traditional PPO	Single	$328.04	$231.90	$559.94	$1,213.20	$1,237.47	$8,529.04	$6,029.40	$0.00	$6,029.40	$14,558.44
	Family	$871.58	$652.86	$1,524.44	$3,302.95	$3,369.01	$22,661.08	$16,974.36	$0.00	$16,974.36	$39,635.44
Traditional PPO W/ Non-Tobacco Use	Single	$293.04	$231.90	$524.94	$1,137.37	$1,160.12	$7,619.04	$6,029.40	$0.00	$6,029.40	$13,648.44
	Family	$836.58	$652.86	$1,489.44	$3,227.12	$3,291.66	$21,751.08	$16,974.36	$0.00	$16,974.36	$38,725.44
Dental	Single	$1.32	$10.38	$11.70	$25.35	$25.86	$34.32	$269.88	$0.00	$269.88	$304.20
	Family	$3.42	$27.30	$30.72	$66.56	$67.89	$88.92	$709.80	$0.00	$709.80	$798.72
Vision	Single	$0.17	$1.47	$1.64	$3.55	$3.62	$4.42	$38.22	$0.00	$38.22	$42.64
	Family	$2.52	$1.64	$4.16	$9.01	$9.19	$65.52	$42.64	$0.00	$42.64	$108.16

Flexible Spending Accounts										
Medical, Limited Purpose Medical (HSA Holders) and/or Dependent Care Admin Fee	$0.00	$1.62	$1.62	$3.51	$3.51	$0.00	$42.12	$0.00	$42.12	$42.12

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

HSA Accounts	Coverage	Initial Contribution *	Bi-Weekly Contribution	Monthly Contribution	Maximum Annual ER Contribution
Wellness	Single	$625.56	$24.06	$52.13	$1,251.12
	Family	$1,251.12	$48.12	$104.26	$2,502.24
HSA 1	Single	$500.76	$19.26	$41.73	$1,001.52
	Family	$1,001.52	$38.52	$83.46	$2,003.04
HSA 2	Single	$299.52	$11.52	$24.96	$599.04
	Family	$599.04	$23.04	$49.92	$1,198.08

*Initial contribution as listed above apply to employees with a CDHP effective between 1/1/16 thru 6/1/16 and with an open HSA. CDHPs effective after 6/1/16 but before 12/1/16 and with an open HSA, will receive 1/2 of the initial contribution..

State of Indiana Rx Benefit Comparison

Copay/co-insurance after deductible is met and before out-of-pocket maximum is satisfied

(applies to all four plans: Wellness CDHP, CDHP 1, CDHP 2 and Traditional PPO).

	Wellness CDHP		CDHP 1		CDHP 2		Traditional PPO	
Prescription drugs	Retail (30 day supply)	Mail (90 day supply)	Retail (30 day supply)	Mail (90 day supply)	Retail (30 day supply)	Mail (90 day supply)	Retail (30 day supply)	Mail (90 day supply)
Preventive (mandated by the ACA)	$0 no deductible	$0 no deductible	$0 no deductible	$0 no deductible	$0 no deductible	$0 no deductible	$0 no deductible	$0 no deductible
Generic	$10 copay	$20 copay	$10 copay	$20 copay	$10 copay	$20 copay	$20 copay	$40 copay
Brand, Formulary	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	30% Min $40 Max $60	30% Min $80 Max $120
Brand, Non-formulary	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	50% Min $70 Max $90	50% Min $140 Max $180
Specialty	40% Min $75, Max $150 (30 day supply)		40% Min $75, Max $150 (30 day supply)		40% Min $75, Max $150 (30 day supply)		50% Min $100, Max $175 (30 day supply)	

Invest In Your Health program

HumanaVitality

Register with Humana Vitality today

HumanaVitality, an incentive based wellness program, empowers people with the tools necessary to reach their optimal health. By participating in health-related activities that can be tracked and measured, such as taking wellness classes, exercising and getting regular medical check-ups and screenings, members earn Vitality Points which are used to determine their Vitality Status. Members earn a Vitality Buck for every Vitality Point earned, which they can redeem for products, services and discounts with HumanaVitality's preferred partners. HumanaVitality is available to employees (and their covered dependents) enrolled in a medical plan offered through the State Personnel Department.

To activate your membership
Visit our.humana.com/investinyourhealth/ and follow these steps:

1. Click the green "sign in or register" button and then "register now as a new user" link.
2. Click "Get Started" button.
3. Under the green Registration heading, there are three tabs. Choose the far right tab titled "All other members". If you do not have your Humana ID card yet, you can enter your birth date and social security number to finish the registration.
   - Dependents/Spouses: have them create an account as well! They will have a different Humana ID number than the plan holder. If they do not know their Humana ID, you can use their birth date and social security number instead.
4. You can also set up your account by downloading the HumanaVitality mobile app from your mobile device app store.

You can also learn more about HumanaVitality on the Invest In Your Health website at www.investinyourhealthindiana.com/humana/.

2017 Wellness CDHP qualification

The State of Indiana is again offering a way to upgrade your health plan during Open Enrollment next fall. Similar to this year, the Wellness Consumer Driven Health Plan (CDHP) offers lower premiums to those who qualify. Look for details January 2016 in your email inbox.

Castlight

Castlight helps you spend your healthcare dollars wisely

Castlight gives you the information you need to make smart health care decisions for you and your family. Using Castlight online or through the mobile app, you can:

- Compare nearby doctors, medical facilities, and health care services based on the price you'll pay and quality of care.
- See personalized cost estimates based on your location, your health plan, and whether or not you've already paid your deductible.
- Review step-by-step explanations of past medical spending so you know how much you paid and why.

Castlight lists prices for doctors and services that have been used by state employees. Although all medical services may not have prices, the most common ones do, and new services are added every month. Essentially, Castlight lets all state employees share the costs of their medical services in a completely anonymous and private way. In this way, employees can help each other lower medical costs for themselves and the state of Indiana.

Get started with Castlight today! Register at https://mycastlight.com/stateofindiana.

Your Anthem Benefits

Anthem

State of Indiana - Wellness Consumer-Driven Health Plan
Blue Access℠ for Health Savings Accounts
Summary of Benefits, Effective January 1, 2016

Please note: As we receive additional guidance and clarification on federal health care reform from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

Covered Benefits	Network	Non-Network
Deductible *Family coverage requires the family deductible to be met before coinsurance applies.* *The single deductible **does not** apply to family coverage.* *(Deductibles are combined network and non-network)*	Single: $2,500 Family: $5,000	
Out-of-Pocket Limit (OOP) (Single/Family) *Family coverage requires the family OOP to be met before 100% coverage applies.* *The single OOP **does not** apply to family coverage.* Out-of-Pockets are combined network and non-network; includes the deductible	Single: $4,000 Family: $8,000 Individual embedded: $6,850	
Physician Home and Office Services Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including office surgeries and allergy serum: • allergy injections (PCP and SCP) and allergy testing • non-routine mammograms • diabetic education (regardless of outpatient setting) • MRAs, MRIs, PETS, C-scans, nuclear cardiology imaging studies and non-maternity related ultrasounds	20%	40%
Preventive Care Services Services include but are not limited to: Annual physical exams, pelvic exams, pap testing, PSA tests, immunizations, annual diabetic eye exam, routine vision and hearing exams • Physician home and office visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility • Routine mammograms • Screening colorectal cancer exam/laboratory testing **All preventive services are limited to one of each service per year per covered member; if the office visit is billed separately or if the primary purpose of the office visit is not for the delivery of a preventive service, cost sharing may be imposed for the office visit**	No deductible/coinsurance	40% (not subject to deductible)
Emergency and Urgent Care • **Emergency Room services @ hospital (facility/other covered services)** • **Urgent Care Center services**	20% 20%	20% 20%
Maternity Services	20%	40%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical care visits, intensive medical care, concurrent care, consultations, surgery and administration of general anesthesia and Newborn exams	20%	40%
Inpatient Facility Services	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	40%
Other Outpatient Services *(including but not limited to):* • Non-surgical outpatient services for example: MRIs, C-scans, chemotherapy, ultrasounds and other diagnostic outpatient services. • Home care services (network/non-network combined) Unlimited visits (includes IV therapy) **(No RN/LPN unless billed through a home health care agency)** • Durable medical equipment and orthotics (network/non-network combined) Unlimited benefit maximum (including medical supplies) • Prosthetic devices unlimited benefit maximum for prosthetics received on an outpatient basis. (Surgical prosthetics do not apply) • Physical medicine therapy day rehabilitation programs	20%	40%
• Hospice care • Ambulance services	20%	20%

Health plans for 2016

Wellness CDHP At A Glance

Covered Benefits	Network	Non-Network
Outpatient Therapy Services **(Combined network and non-network limits apply)** • Physician Home and Office Visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility • Physical therapy: 25 visits • Occupational therapy: 25 visits • Manipulation therapy: 12 visits • Speech therapy: 25 visits	20%	40%
Behavioral Health Services: **Mental Health and Substance Abuse**[1] • Inpatient facility services (Residential MH/SA covered as inpatient) • Physician home and office visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility **Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained, benefits will not be allowed.**	20%	40%
Human Organ and Tissue Transplants[2] • Acquisition and transplant procedures, harvest and storage	20%	40%

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

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

	Retail Rx (Up to a 30-day supply)	Mail Order Rx (Up to a 90-day supply)
Generic	$10 co-pay	$20 co-pay
Formulary	20% - minimum $30, maximum $50	20% - minimum $60, maximum $100
Brand Non-Formulary	40% - minimum $50, maximum $70	40% - minimum $100, maximum $140
Specialty	40% - minimum $75, maximum $150 (30-day supply only)	
Preventive (mandated by the ACA)	$0 (no deductible)	

Notes:

- *Non-network human organ and tissue transplants are excluded from the out-of-pocket limits.*
- *Dependent Age: to end of the month which the child attains age 26*
- *No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a non-network provider, the member is responsible for any balance due after the plan payment.*
- *Benefit Period = calendar year.*
- *Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.*
- *Skilled Nursing Facility – limited to 100 days.*

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

Precertification:

- *Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Your Anthem Benefits

Anthem

State of Indiana - Consumer-Driven Health Plan 1
Blue Access℠ for Health Savings Accounts
Summary of Benefits, Effective January 1, 2016

Please note: As we receive additional guidance and clarification on federal health care reform from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

Covered Benefits	Network	Non-Network
Deductible *Family coverage requires the family deductible to be met before coinsurance applies.* *The single deductible **does not** apply to family coverage.* *(Deductibles are combined network and non-network)*	Single: $2,500 Family: $5,000	
Out-of-Pocket Limit (OOP) (Single/Family) *Family coverage requires the family OOP to be met before 100% coverage applies.* *The single OOP **does not** apply to family coverage.* Out-of-Pockets are combined network and non-network; includes the deductible	Single: $4,000 Family: $8,000 Individual embedded: $6,850	
Physician Home and Office Services Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including office surgeries and allergy serum: • allergy injections (PCP and SCP) and allergy testing • non-routine mammograms • diabetic education (regardless of outpatient setting) • MRAs, MRIs, PETS, C-scans, nuclear cardiology imaging studies and non-maternity related ultrasounds	20%	40%
Preventive Care Services Services include but are not limited to: Annual physical exams, pelvic exams, pap testing, PSA tests, immunizations, annual diabetic eye exam, routine vision and hearing exams • Physician home and office visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility • Routine mammograms • Screening colorectal cancer exam/laboratory testing **All preventive services are limited to one of each service per year per covered member; if the office visit is billed separately or if the primary purpose of the office visit is not for the delivery of a preventive service, cost sharing may be imposed for the office visit**	No deductible/coinsurance	40% (not subject to deductible)
Emergency and Urgent Care • **Emergency Room services @ hospital (facility/other covered services)** • **Urgent Care Center services**	20% 20%	20% 20%
Maternity Services	20%	40%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical care visits, intensive medical care, concurrent care, consultations, surgery and administration of general anesthesia and Newborn exams	20%	40%
Inpatient Facility Services	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	40%
Other Outpatient Services *(including but not limited to):* • Non-surgical outpatient services for example: MRIs, C-scans, chemotherapy, ultrasounds and other diagnostic outpatient services. • Home care services (network/non-network combined) Unlimited visits (includes IV therapy) **(No RN/LPN unless billed through a home health care agency)** • Durable medical equipment and orthotics (network/non-network combined) Unlimited benefit maximum (including medical supplies) • Prosthetic devices unlimited benefit maximum for prosthetics received on an outpatient basis. (Surgical prosthetics do not apply) • Physical medicine therapy day rehabilitation programs	20%	40%
• Hospice care • Ambulance services	20%	20%

Health plans for 2016

CDHP 1 At A Glance

Covered Benefits	Network	Non-Network
Outpatient Therapy Services **(Combined network and non-network limits apply)** • Physician Home and Office Visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility • Physical therapy: 25 visits • Occupational therapy: 25 visits • Manipulation therapy: 12 visits • Speech therapy: 25 visits	20%	40%
Behavioral Health Services: **Mental Health and Substance Abuse**[1] • Inpatient facility services • Physician home and office visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility **Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained, benefits will not be allowed.**	20%	40%
Human Organ and Tissue Transplants[2] • Acquisition and transplant procedures, harvest and storage	20%	40%

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

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

	Retail Rx (Up to a 30-day supply)	Mail Order Rx (Up to a 90-day supply)
Generic	$10 co-pay	$20 co-pay
Formulary	20% - minimum $30, maximum $50	20% - minimum $60, maximum $100
Brand Non-Formulary	40% - minimum $50, maximum $70	40% - minimum $100, maximum $140
Specialty	40% - minimum $75, maximum $150 (30-day supply only)	
Preventive Rx (mandated by the ACA)	$0 (no deductible)	

Notes:

- *Non-network human organ and tissue transplants are excluded from the out-of-pocket limits.*
- *Dependent Age: to end of the month which the child attains age 26*
- *No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a non-network provider, the member is responsible for any balance due after the plan payment.*
- *Benefit Period = calendar year.*
- *Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.*
- *Skilled Nursing Facility – limited to 100 days.*

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

Precertification:

- *Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Your Anthem Benefits

Anthem

State of Indiana - Consumer-Driven Health Plan 2
Blue Access℠ for Health Savings Accounts
Summary of Benefits, Effective January 1, 2016

Please note: As we receive additional guidance and clarification on federal health care reform from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

Covered Benefits	Network	Non-Network
Deductible *Family coverage requires the family deductible to be met before coinsurance applies.* *The single deductible **does not** apply to family coverage.* *(Deductibles are combined network and non-network)*	Single: $1,500 Family: $3,000	
Out-of-Pocket Limit (OOP) (Single/Family) *Family coverage requires the family OOP to be met before 100% coverage applies.* *The single OOP **does not** apply to family coverage.* Out-of-Pockets are combined network and non-network; includes the deductible	Single: $3,000 Family: $6,000	
Physician Home and Office Services Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including office surgeries and allergy serum: • allergy injections (PCP and SCP) and allergy testing • non-routine mammograms • MRAs, MRIs, PETS, C-scans, nuclear cardiology imaging studies and non-maternity related ultrasounds • Diabetic education (regardless of outpatient setting)	20%	40%
Preventive Care Services Services include but are not limited to: Annual physical exams, pelvic exams, pap testing, PSA tests, immunizations, annual diabetic eye exam, routine vision and hearing exams • Physician home and office visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility • Routine mammograms • Screening colorectal cancer exam/laboratory testing **All preventive services are limited to one of each service per year per covered member; if the office visit is billed separately or if the primary purpose of the office visit is not for the delivery of a preventive service, cost sharing may be imposed for the office visit**	No deductible/coinsurance	40% (not subject to deductible)
Emergency and Urgent Care • **Emergency Room services @ hospital (facility/other covered services)** • **Urgent Care Center services**	20% 20%	20% 20%
Maternity Services	20%	40%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical care visits, intensive medical care, concurrent care, consultations, surgery and administration of general anesthesia and Newborn exams	20%	40%
Inpatient Facility Services	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	40%
Other Outpatient Services *(including but not limited to):* • Non-surgical outpatient services for example: MRIs, C-scans, chemotherapy, ultrasounds and other diagnostic outpatient services. • Home care services (network/non-network combined) Unlimited visits (includes IV therapy) **(No RN/LPN unless billed through a home health care agency)** • Durable medical equipment and orthotics (network/non-network combined) Unlimited benefit maximum (including medical supplies) • Prosthetic devices unlimited benefit maximum for prosthetics received on an outpatient basis. (Surgical prosthetics do not apply) • Physical medicine therapy day rehabilitation programs	20%	40%
• Hospice care • Ambulance services	20%	20%

Health plans for 2016

CDHP 2 At A Glance

Covered Benefits	Network	Non-Network
Outpatient Therapy Services **(Combined network and non-network limits apply)** • Physician Home and Office Visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility • Physical therapy: 25 visits • Occupational therapy: 25 visits • Manipulation therapy: 12 visits • Speech therapy: 25 visits	20%	40%
Behavioral Health Services: **Mental Health and Substance Abuse**[1] • Inpatient facility services • Physician home and office visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility **Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained, benefits will not be allowed.**	20%	40%
Human Organ and Tissue Transplants[2] • Acquisition and transplant procedures, harvest and storage	20%	40%

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

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

	Retail Rx (Up to a 30-day supply)	Mail Order Rx (Up to a 90-day supply)
Generic	$10 co-pay	$20 co-pay
Formulary	20% - minimum $30, maximum $50	20% - minimum $60, maximum $100
Brand Non-Formulary	40% - minimum $50, maximum $70	40% - minimum $100, maximum $140
Specialty	40% - minimum $75, maximum $150 (30 day supply only)	
Preventive (mandated by the ACA)	$0 (no deductible)	

Notes:

- *Non-network human organ and tissue transplants are excluded from the out-of-pocket limits.*
- *Dependent Age: to end of the month which the child attains age 26*
- *No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a non-network provider, the member is responsible for any balance due after the plan payment.*
- *Benefit Period = calendar year.*
- *Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.*
- *Skilled Nursing Facility – limited to 100 days.*

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

Precertification:

- *Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

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

Invest In Your Health

Your Anthem Benefits

Anthem

State of Indiana - Traditional PPO
Blue Access℠ (PPO)
Summary of Benefits, Effective January 1, 2016

Please note: As we receive additional guidance and clarification on federal health care reform from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

Covered Benefits	Network	Non-Network
Deductible *Family coverage requires the family deductible to be met before coinsurance applies.* *The single deductible **does not** apply to family coverage.*	Single $750 Family $1,500	Single $1,500 Family $3,000
Out-of-Pocket Limit (OOP) (Single/Family) *Family coverage requires the family OOP to be met before 100% coverage applies.* *The single OOP **does not** apply to family coverage.*	Single $3,000 Family $6,000	Single $6,000 Family $12,000
Physician Home and Office Services Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including office surgeries and allergy serum: • allergy injections (PCP and SCP) and allergy testing • non-routine mammograms • diabetic education (regardless of outpatient setting) • MRAs, MRIs, PETS, C-scans, nuclear cardiology imaging studies and non-maternity related ultrasounds	30%	50%
Preventive Care Services Services include but are not limited to: Annual physical exams, pelvic exams, pap testing, PSA tests, immunizations, annual diabetic eye exam, routine vision and hearing exams • Physician home and office visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility • Routine mammograms • Screening colorectal cancer exam/laboratory testing **All preventive services are limited to one of each service per year per covered member; if the office visit is billed separately or if the primary purpose of the office visit is not for the delivery of a preventive service, cost sharing may be imposed for the office visit**	No deductible/coinsurance	50% (not subject to deductible)
Emergency and Urgent Care • **Emergency Room services @ hospital (facility/other covered services)** • **Urgent Care Center services**	30% 30%	30% 30%
Maternity Services	30%	50%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical care visits, intensive medical care, concurrent care, consultations, surgery and administration of general anesthesia and Newborn exams	30%	50%
Inpatient Facility Services	30%	50%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	30%	50%
Other Outpatient Services *(including but not limited to):* • Non-surgical outpatient services for example: MRIs, C-scans, chemotherapy, ultrasounds and other diagnostic outpatient services. • Home care services (network/non-network combined) Unlimited visits (includes IV therapy) **(No RN/LPN unless billed through a home health care agency)** • Durable medical equipment and orthotics (network/non-network combined) Unlimited benefit maximum (including medical supplies) • Prosthetic devices unlimited benefit maximum for prosthetics received on an outpatient basis. (Surgical prosthetics do not apply) • Physical medicine therapy day rehabilitation programs	30%	50%
• Hospice care • Ambulance services	30%	30%

Health plans for 2016

Traditional PPO At A Glance

Covered Benefits	Network	Non-Network
Outpatient Therapy Services **(Combined network and non-network limits apply)** • Physician Home and Office Visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility • Physical therapy: 25 visits • Occupational therapy: 25 visits • Manipulation therapy: 12 visits • Speech therapy: 25 visits	30%	50%
Behavioral Health Services: **Mental Health and Substance Abuse**[1] • Inpatient facility services • Physician home and office visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility **Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained, benefits will not be allowed.**	30%	50%
Human Organ and Tissue Transplants[2] • Acquisition and transplant procedures, harvest and storage	30%	50%

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

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

	Retail Rx (Up to a 30-day supply)	Mail Order Rx (Up to a 90-day supply)
Generic	$20 co-pay	$40 co-pay
Formulary	30% - minimum $40, maximum $60	30% - minimum $80, maximum $120
Brand Non-Formulary	50% - minimum $70, maximum $90	50%, minimum $140, maximum $180
Specialty	50% minimum $100, maximum $175 (30 day supply only)	
Preventive (mandated by the ACA)	$0 (no deductible)	

Notes:

- *Non-network human organ and tissue transplants are excluded from the out-of-pocket limits.*
- *Dependent Age: to end of the month which the child attains age 26*
- *No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a non-network provider, the member is responsible for any balance due after the plan payment.*
- *Benefit Period = calendar year.*
- *Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.*
- *Skilled Nursing Facility – limited to 100 days.*

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

Precertification:

- *Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Health Savings Accounts (HSA)

State continues to contribute to Health Savings Account

The state will contribute 39% percent or more of the Consumer-Driven Health Plan (CDHP) annual deductible to your Health Savings Account (HSA) in 2016 depending on what plan you choose. The initial contribution will be made on the first checks in January. Employees enrolled in a CDHP effective from Jan. 1, 2016, through June 1, 2016, will receive the full pre-fund amount. CDHPs effective after June 2, 2016, but before Dec. 2, 2016, will receive one-half of the initial contribution. The initial pre-fund contribution is based on the coverage type (single/family) that is effective Jan. 1, 2016.

If you have an active HSA with The HSA Authority at Old National Bank and wish to continue receiving the state's contributions in 2016, you do not need to open a new HSA account with The HSA Authority. If you wish to change your contribution to your account or begin contributing for 2016, you need to access your PeopleSoft record and enter your desired contribution. **If you do not change your HSA contribution, it will not carry over for the 2016 plan year.**

If you are electing to participate in a HSA for the first time in 2016, 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 will need to open an HSA account with The HSA Authority before Jan. 1, 2016.

State contribution to health savings accounts in 2016

HSA Account	Coverage	Initial Contribution	Bi-Weekly Contribution	Monthly Contribution	Maximum Annual ER Contribution
HSA w/ Wellness CDHP 1	Single Family	$625.56 $1251.12	$24.06 $48.12	$52.13 $104.26	$1,251.12 * $2,502.24
HSA 1 w/ CDHP 1	Single Family	$500.76 $1,001.52	$19.26 $38.52	$41.73 $83.46	$1,001.52 $2,003.04
HSA 2 w/ CDHP 2	Single Family	$299.52 $599.04	$11.52 $23.04	$24.96 $49.92	$599.04 $1,198.08

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.

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 click on the "Enroll Now" 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, click this button and insert your employer code below. Enter **100366** in the "employer code" and it will begin the state application.

You will 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 process)

The HSA Authority™ Old National Bank

2016

Education & Enrollment Packet

HSA Basics

A health savings account (HSA) is a tax-advantaged checking account that gives you the ability to save for future medical expenses or pay current ones. It is individually owned; however, you may elect to designate an authorized signer who may also withdrawal funds and be issued a debit card.

HSA Eligibility

To be eligible to make deposits to an HSA, you:

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

Contributions to your HSA

The annual maximum allowable contributions to an HSA, as established by the IRS, for 2016 are:

- Individual: $3,350
- Family: $6,750

Individuals 55 and older can make an additional catch-up contribution of $1,000 in 2016. A married couple can make two catch-up contributions if both spouses are eligible. The spouses must deposit the catch-up contributions into separate accounts.

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

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

Distributions from your HSA

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

Advantages of an HSA

Portability:

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

Flexibility:

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

Tax Savings:

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

Premium Savings:

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

Allowable Expenses

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

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

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

Examples of Allowable Expenses:

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

Non-Allowable Expenses

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

Costs associated with non-medically necessary treatments are not eligible. This includes cosmetic surgery and items meant to improve one's general health (but which are not due to a specific injury, illness or disease) such as health club dues, gym memberships, vitamins and nutritional supplements.

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

Examples of Non-Allowable Expenses:

- Advance Payment for Future Medical Expenses
- Automobile Insurance Premium
- Baby-sitting (healthy children)
- Commuting Expenses for the Disabled
- Controlled Substances
- Cosmetics and Hygiene Products
- Diaper Service
- Domestic Help
- Electrolysis (hair removal)
- Funeral Expenses
- Hair Transplant
- Health Club and Gym Memberships
- Household Help
- Illegal Operations and Treatments
- Illegally Procured Drugs
- Maternity Clothes
- Non-Prescription Medicines (as of January 1, 2011)
- Nutritional Supplements
- Premiums for Accident Insurance
- Premiums for HSA Qualified Health Plan (prior to age 65)
- Premiums for Life or Disability Insurance
- Scientology Counseling
- Teeth Whitening
- Travel for General Health Improvement
- Tuition in a Particular School for Problem

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

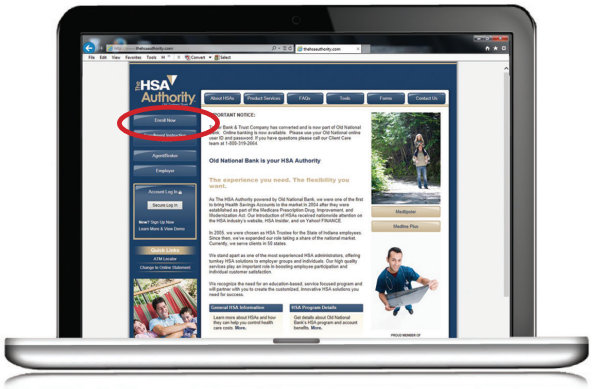
Opening Your HSA Online

You'll need the following information when you begin:

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

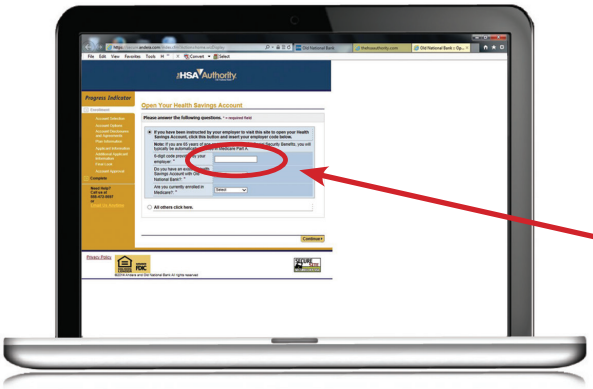
Complete the following steps to open your account:

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



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

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



Employer Name:

State of Indiana

Employer Code:

100366

3. Click the "Continue" button at the bottom of the screen to continue the account opening process.
4. Once you have successfully submitted your enrollment application, a confirmation number will appear.
5. After completing the online enrollment, you'll receive a welcome letter in the mail with your new HSA information.
6. If you requested a debit card it will be mailed separately and will arrive following the welcome letter. If checks are requested, the order is held and processed after your balance reaches $25.00.

Online Banking & eStatements

Your Welcome Letter contains your new HSA number along with instructions for accessing Old National Bank's online banking site and telephone banking system. If you choose eStatements, be sure to follow the instructions in the welcome letter to activate your eStatement election. If you'd like assistance using these services, please call our Client Care Center toll-free at 888.472.8697.

The HSA Authority™
Old National Bank

Website Features

Visit theHSAauthority.com for helpful tools!

HSA Calculators

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

Health Information Links

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

HSA Resources

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

Medtipster

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

Forms and Address Changes

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

Online Messages and Address Changes

When signed in to Online Banking, you can quickly and easily request an address change, send a message or request information from our Client Care team.

Contact Us

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

HSA28B-08.15

HSAs at Tax Time

- You'll receive **Form 1099 SA** for your distribution total and **Form 5498 SA** for your contribution total for the previous year. These figures are reported to the IRS and you are required to report them on IRS Form 8889 when filing your federal taxes. See IRS Publication 969 or consult your tax advisor for further information.
- You may make contributions to your HSA for the previous calendar year up to the tax filing deadline, which is normally April 15th. If you make prior year deposits, you will receive an **updated Form 5498 SA** in May with your complete contribution total to keep with your tax records.

Prior Year Deposits: Prior year contributions should be clearly communicated to bank personnel. If mailing a deposit, be sure to note it is for the prior year. Deposits made at an ATM machine, remote deposit using your mobile phone, electronic transfers made using any method or those that are not specifically communicated to bank personnel will automatically be processed as a current year contribution.

Insurance Coverage Changes

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

What If...

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

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

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

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

1. Write a check to yourself.
2. Make an ATM withdrawal.
3. Purchase non-medical items with HSA debit card equal to the medical expense, save the receipts and make notes for your records.
4. Use Online Bill Payment to mail a check to yourself.
5. Complete and submit a Withdrawal Authorization form found under the Forms tab on the website.

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

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

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

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

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

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

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

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

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

Product Features

Enrollment Fee	**Free** online enrollment
Minimum Opening Balance	None
Annual Fee	None
Service Charge	No monthly service charge
Statement Options	Online or paper statements available
Interest Rates	Interest rates may vary based on account balance; rates subject to change; refer to our website for information or call our Client Care Center
Annual IRS Reporting and Updates	5498-SA (contributions), 1099-SA (distributions), and adjustments for prior year contributions
24/7 Automated Telephone Banking	Toll-free number 1-800-731-2265
Deposit Processing	Automatic deposit, mail in service, or in-person at any Old National location
Online Banking	**Free** access to view statements, account activity, balance, and front and back of paid checks
Online Bill Pay	**Free** access to pay bills online through online banking
Debit Card	**Free** debit cards for account owner and authorized signer
ATM Access	**Free** ATM withdrawals at any Old National ATM; fees will apply for ATM withdrawals at non-Old National ATM's; refer to bank fee schedule
Check Fees	No per-check fees; see website for current printing fee per order of 30 checks
Certificate of Deposit Options	Available; call Client Care at 1.888.472.8697, option 2 for current rates and terms; FDIC insured
Investment Options[1]	Available; call Client Care at 1.888.472.8697, option 2 for more information; $36 Annual Fee
Bank Service fees (overdraft, stop pay, etc.)	Call Client Care at 1.888.472.8697, option 1 for details

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

Address: The HSA Authority; PO Box 11454; Fort Wayne, IN 46858
Email: info@theHSAauthority.com
Phone: 888.472.8697, Monday through Friday 8am – 8pm and Saturday 8am – 1pm ET

[1] Not FDIC Insured | No Bank Guarantee | May Lose Value | Not a Deposit | Not Insured by any Federal Government Agency

*Please consult your insurance advisor about available plan options.

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Health Savings Accounts (HSA)

HSAs have a maximum contribution limit

Contributions are allowed up to the maximum statutory limit. The maximum annual contribution for 2016 is $3,350 for self-only policies and $6,750 for family policies. Individuals age 55 and over may make an additional catch up contribution of up to $1,000 in 2016. Combined household contributions cannot exceed the family limit. The maximum includes the state's contributions and any other contributions to your HSA.

Medicare, Medicaid and HIP disqualify you from having a Health Saving Account

The IRS established Health Savings Accounts 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. 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.

Based on the above eligibility qualifications, enrolling in Medicare, Medicaid or HIP 2.0 will disqualify you from having contributions into a Health Savings Account (HSA). Once enrolled in any of these plans, you may not receive or make any contributions into a HSA. For more information about HSAs please see IRS Publication 969 at http://www.irs.gov/pub/irs-pdf/p969.pdf.

Although you can no longer make contributions to your HSA once you are covered by Medicare, Medicaid or HIP 2.0 the money that has accumulated in your HSA from past years remains yours to spend, tax-free, on eligible expenses, including Medicare co-pays 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 at age 62 or older, you will automatically be enrolled in Medicare Part A when you turn age 65. If you wish to participate in the HSA, you should decline to receive Social Security retirement benefits and waive Medicare Part A. Keep in mind that 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 6 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 the 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 2.0

According to IRS regulations, an individual who is enrolled in Medicaid is not eligible to make or receive contributions into 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 but you are not, you may continue to receive contributions into your HSA. Eligibility is based on the subscriber/account holder.

Flexible Spending Accounts (FSA)

FSAs can provide tax-free help for qualified medical expenses with no administration fee this year

A Flexible Spending Account (FSA) provides another opportunity for you to better control your health care dollars. By tucking away pre-tax dollars from your paycheck, you have an account that's dedicated for the reimbursement of qualified medical, vision and dental expenses. In addition, the bi-weekly employee administration fee is being paid by the State during the 2016 plan year, providing you with even more opportunities to save.

The state's FSA program is administered through Key Benefits Administrators. All FSAs offered by the state have a use-it-or-lose-it rule. Money left at the end of the plan year is not rolled over or reimbursed, so plan carefully.

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

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

For 2016, the maximum annual contribution for the Medical Care and Limited Purpose FSAs is $2,500.

A Limited Purpose FSA may only be used for dental, vision and preventive care expenses until the minimum deductible of a CDHP is met ($1,300 for single and $2,600 for family, per federal regulations). Once the minimum deductible is met, the Limited Purpose FSA can be used as a Medical Care FSA.

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

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 day care.

Dependent Care FSAs are not front-loaded. 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).

Dependent care costs include most dependent care expenses for eligible children and adults. Dependent care expenses do not include medical expenses and therefore can be used even if you participate in a HSA.

2016 BENEFITS OPEN ENROLLMENT

Are there other ways to save besides a HSA?

Flexible Spending Accounts (FSA) provide another opportunity to set aside pre-tax dollars from each paycheck for reimbursement of qualified medical and/or dependent daycare expenses. The maximum contribution to a medical flexible spending account in 2016 is $2,500 annually. This applies to both the medical FSA and the limited purpose medical FSA. The dependent care FSA will continue to have a $5,000 annual contribution limit.

You must re-enroll in medical and dependent care FSAs each year if you wish to continue to participate. If you continue participation in the Medical FSA, do not discard the debit card from Key Benefit Administrators. New cards are not automatically issued each year.

Effective January 1, 2016, the biweekly administrative fee will be waived. As a reminder, FSAs have a "use-it-or-lose-it" rule. Money left at the end of the plan year is not rolled over or reimbursed, so plan carefully.

Prescription drug benefits

Express Scripts provides more than just prescriptions

Pharmacy benefits for all state health plans are provided by Express Scripts. All three of the Consumer-Driven Health Plans (CDHPs) have the same prescription coverage while the Traditional PPO has slightly higher copays, coinsurance rates and min/max amounts.

EXPRESS SCRIPTS®

Express Scripts' website (www.express-scripts.com) offers several cost-and time-saving features. For instance, you can review the claims that have been submitted for your 2015 prescriptions to help you make an informed decision about your 2016 election. Then, take it a step further, and shop for the lowest price on your medications. Enter the name of your prescription and the website lists the price and any generics or other options for treatment of your particular condition. This helps you to make informed investments of your healthcare dollars.

Keep in mind that in addition to retail pharmacies, you can utilize Express Scripts mail order pharmacy. They offer a 90-day supply on some medications. After you meet your deductible, you can purchase a 90-day supply for the cost of 60 days. That could provide you quite a savings. Armed with the costs of your medications, that information could help you better calculate your prescription costs for 2016.

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

Learn more about Express Scripts by visiting www.express-scripts.com or call, toll free 1-877-841-5241.

State of Indiana Rx Benefit Comparison

Copay/co-insurance after deductible is met and before out-of-pocket maximum is satisfied

(applies to all four plans: Wellness CDHP, CDHP 1, CDHP 2 and Traditional PPO).

	Wellness CDHP		CDHP 1		CDHP 2		Traditional PPO	
Prescription drugs	Retail (30 day supply)	Mail (90 day supply)	Retail (30 day supply)	Mail (90 day supply)	Retail (30 day supply)	Mail (90 day supply)	Retail (30 day supply)	Mail (90 day supply)
Preventive (mandated by the ACA)	$0 no deductible	$0 no deductible	$0 no deductible	$0 no deductible	$0 no deductible	$0 no deductible	$0 no deductible	$0 no deductible
Generic	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay
Brand, Formulary	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	30% Min $40 Max $60	30% Min $80 Max $120
Brand, Non-formulary	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	50% Min $70 Max $90	50% Min $140 Max $180
Specialty	40% Min $75, Max $150 (30 day supply)		40% Min $75, Max $150 (30 day supply)		40% Min $75, Max $150 (30 day supply)		50% Min $100, Max $175 (30 day supply)	

Dental Coverage

New dental provider for 2016

State Personnel is pleased to announce that as of January 1, Anthem will be the new Dental provider. If you are currently enrolled in dental, your coverage will automatically transfer to Anthem. However, if you wish to enroll, change your level of coverage or change your dental dependents, you will need to actively make these selections within your Open Enrollment event.

Dental	2016 Bi-Weekly Rate
Single	$1.32
Family	$3.42

In addition to the insurance provider change, the state is excited to announce that the orthodontic services benefit will be increasing. The new lifetime maximum for orthodontic services will be $1,500 per eligible person.

Anthem Dental Complete will continue to provide 100 percent diagnostic and preventive coverage, as long as an in-network dentist is used. The plan also covers 100 percent of emergency palliative treatment (used to temporarily relieve pain), x-rays and sealants (to prevent decay of pits and fissures of permanent back teeth). There are limits to the coverage of sealants, however, so check with Anthem before agreeing to the treatment. You can save money by using an in-network dentist. To find an in-network dentist please visit Anthem.com and search dentist within the Anthem Dental Complete network.

Please be aware that the dental rates have changed slightly from last year. Below is a breakdown of the cost.

Vision Coverage

Anthem remains vision provider for 2016

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

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

The Anthem Vision plan and premiums will remain the same for 2016. Through Blue View Vision Select, you have access to a wide selection of experienced opticians. Many of these optician are located in convenient retail locations and offer evening and weekend hours. To get the most cost savings, it is important to seek care from an in-network provider. To find out which opticians are in your network please visit www.Anthem.com or call Blue View Vision Select toll-free at (877)254-9443.

Under Blue View Vision, you are authorized to receive an eye exam every 12 months, frames every 24 months and contact lenses once every 12 months.

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

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

1. Visit www.anthem.com and select “Find a doctor” on the right.
2. You can “Search as a Member” with your Anthem account, your Identification number, or “Search as Guest”.

The Anthem Dental Complete and the Anthem Blue View Vision Plan Summaries follow on the next five pages.

Anthem BlueCross BlueShield

Your Summary of Benefits
State of Indiana – 2016
Anthem Dental Complete

WELCOME TO YOUR DENTAL PLAN!
This benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your employee benefits booklet.

Dental coverage you can count on
Your Anthem dental plan lets you visit any licensed dentist or specialist you want – with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits – you get more for your money.
You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

YOUR DENTAL PLAN AT A GLANCE	In-Network	Out-of-Network
Annual Benefit Maximum – (Calendar Year) • Per insured person **Annual Maximum Carryover**	**$1,000** **No**	**$1,000** **No**
Orthodontic Lifetime Benefit Maximum • Per eligible insured person	**$1,500**	**$1,500**
Annual Deductible – (Calendar Year) • Per insured person • Family maximum	**$50** **$150 family maximum**	**$50** **$150 family maximum**
Deductible Waived for Diagnostic & Preventive Services and Orthodontic Services	**Yes**	**Yes**

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:
Diagnostic and Preventive Services • Periodic oral exam • Teeth cleaning (prophylaxis) • Bitewing X-rays (once in calendar year for all ages) • Intraoral X-rays	**100% coinsurance**	**90% coinsurance**
Basic Services • Amalgam (silver-colored) Filling • Front composite (tooth-colored) Filling • Back Composite Filling, alternated to amalgam allowance • Simple Extractions • Crowns	**80% coinsurance**	**70% coinsurance**
Endodontics • Root canal	**80% coinsurance**	**70% coinsurance**
Periodontics • Scaling and root planing	**80% coinsurance**	**70% coinsurance**
Oral Surgery • Surgical Extractions	**80% coinsurance**	**70% coinsurance**
Major Restorative • Onlays and Inlays	**60% coinsurance**	**50% coinsurance**
Prosthodontics • Dentures • Bridges • Dental Implants (covered)	**60% coinsurance**	**50% coinsurance**
Prosthetic Repairs/Adjustments	**80% coinsurance**	**70% coinsurance**
Orthodontic Services • Adults and dependent children*	**60% coinsurance**	**50% coinsurance**

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your employee benefits booklet. **In the event of a discrepancy between the information in this summary and the employee benefits booklet, the booklet will prevail.**

Anthem BlueCross BlueShield

Emergency dental treatment for the international traveler

As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.** With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

** The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Anthem. To learn more about the program, please visit the International Emergency Dental Web site at www.decaredental.com/internationalDentalProgram.do.

Finding a dentist is easy.

To select a dentist by name or location, do one of the following:

- Go to anthem.com
- Call Anthem dental customer service at the toll free number at 1-877-814-9709.

TO CONTACT US:

Call	Write
Refer to the toll-free number at 1-877-814-9709 to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may be able to assist you with our interactive voice-response system.	Anthem Dental Claims PO Box 1115 Minneapolis MN 55440-1115

Limitations & Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your employee benefits booklet for a full list.

Diagnostic and Preventive Services

Oral evaluations (exam) Limited to two per Calendar Year

Teeth cleaning (prophylaxis) Limited to two per Calendar Year

Intraoral X-rays, single film Limited to four films per 12-month period

Complete series X-rays (panoramic or full-mouth) Limited to once every three years

Topical fluoride application Limited to once every 12 months for members through age 13

Sealants Limited to first and second molars once per lifetime per tooth for members through age 15

Space Maintainers Limited to extracted primary posterior teeth for members through age 18

Basic and/or Major Services

Fillings Limited to once per surface per tooth in any 24 months

Crowns Limited to once per tooth in a seven-year period

Fixed or removable prosthodontics – dentures, partials, bridges, tooth implants

Covered once in any seven-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is seven years old or older and cannot be made serviceable.

Root canal therapy Limited to once per lifetime per tooth; coverage is for permanent teeth only.

Periodontal surgery Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

Periodontal scaling and root planing Limited to once per quadrant in 36 months, when the tooth pocket has a depth of four millimeters or greater

Brush biopsy (Not covered)

ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES – *if Orthodontia is included as a benefit of your dental plan*

Orthodontia Limited to one course of treatment per member per lifetime

Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your employee benefits booklet for a full list.

Services provided before or after the term of this coverage Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) Orthodontic braces, appliances and all related services

Cosmetic dentistry Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Extractions Surgical removal of third molars (wisdom teeth) that do not exhibit symptoms or impact the oral health of the member

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross Life and Health Insurance Company.

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), and Healthy Alliance® Life Insurance Company (HALIC). RIT and certain affiliates administer non-HMO benefits underwritten by HALIC. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWi), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (Compcare), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Choice of dentists
While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist.

Here's why:
In-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service – called the "maximum allowed cost" – and the amount they usually charge for a service. When they bill you for this difference, it's called "balance billing."

How Anthem dental decides on maximum allowed costs
For services from an out-of-network dentist, the maximum allowed cost is determined in one of the following ways:

- Out-of-network dental fee schedule/rate developed by Anthem, which may be updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data
- Information provided by a third-party vendor that shows comparable costs for dental services
- In-network dentist fee schedule

Here's an example of higher costs for out-of-network dental services
This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Say Ted's dental plan allows him 50% coinsurance for either in- or out-of-network services... Ted chooses to get a crown from an out-of-network dentist who charges $1,200 for the service and bills Anthem for that amount. If Anthem's maximum allowed cost for this dental service is $800, this means there will be a $400 difference. The out-of-network dentist can "balance bill" Ted for that amount.

Ted will also need to pay $400 coinsurance. Therefore, the total he will pay the out-of-network dentist is $800. Here's the math:

- Dentist's charge: $1,200
- Anthem's maximum allowed cost: $800
- Anthem pays 50%: $400
- Ted pays 50% (coinsurance): **$400**
- Balance Ted owes the provider: $1,200 - $800 = **$400**
- Ted's total cost: **$400** coinsurance + **$400** provider balance = **$800**

In the example, if Ted had gone to an in-network dentist, his cost would be only $400 for the coinsurance because he would not have been "balance billed" the $400 difference.

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9/2015

INTRODUCING BLUE VIEW VISION-Select!

Good news—Blue View Vision-Select is very flexible and easy to use. This summary outlines the basic components of your plan, including quick answers about what's covered and much more!

STATE OF INDIANA has selected Anthem Blue View Vision Select as your vision wellness program. Blue View Vision Select offers you one of the most robust vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Anthem Blue Cross and Blue Shield members have access to one of the nation's largest vision networks. Blue View Vision Select is the only vision plan that gives members the ability to use their in-network benefits at 1-800 CONTACTS, or choose a private practice eye doctor, or go in store to LensCrafters®, Sears OpticalSM, Target Optical®, JCPenney® Optical and most Pearle Vision® locations. Best of all – when you receive care from a Blue View Vision Select participating provider, you can maximize your benefits and money-saving discounts. Members may call Blue View Vision Select toll-free at (877) 254-9443 with questions about vision benefits or provider locations.

Out-of-Network Services

Did we mention we're flexible? You can choose to receive care outside of the Blue View Vision Select network. You simply get an allowance toward services and you pay the rest. (In-network benefits and discounts will not apply.) Just pay in full at the time of service and then file a claim for reimbursement.

1 800 CONTACTS

LENSCRAFTERS

JCPenney jcp.com

OPTICAL

PEARLE VISION

Sears Optical

Blue View Vision℠ Select

Anthem

STATE OF INDIANA 2016

Vision Care Services	Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary	$10 Copay	Up to $35
Contact Lens Fit and Follow-up: (A contact lens fitting and two follow-up visits are available to you once a comprehensive eye exam has been completed.)		
Standard*	$40 Copay Paid-in-full fit and two follow up visits	Up to $35
Premium**	10% off retail	Up to $35
Frames	Up to $110 allowance	Up to $35
Standard Plastic Lenses:		
Single Vision	$25 Copay	Up to $25
Bifocal	$25 Copay	Up to $40
Trifocal	$25 Copay	Up to $55
Standard Polycarbonate (add-on the lens copay)	$20 Copay	N/A
Lens Option (paid by member and added to the base price of the lens):		
Tint	$15	N/A
UV Coating	$15	N/A
Standard Scratch-Resistant	$15	N/A
Standard Progressive (add-on to bifocal)	$65	N/A
Standard Anti-Reflective	$45	N/A
Other Add-ons	20% off retail	N/A
Contact Lenses (allowance covers materials only):		
Conventional Elective	$0 Copay; $105 allowance 15% off balance over $105	Up to $95
Disposable Elective	$0 Copay; $105 allowance	Up to $95
Non-elective	$0 Copay; Paid in full	Up to $165
Low Vision (subject to prior approval)	$0 Copay $1,000 Lifetime Max.	$0 Copay $1,000 Lifetime Max.
Frequency:		
Exam	Once every 12 months	
Frames	Once every 24 months	
Standard Plastic Lenses or Contact Lenses	Once every 12 months	

*A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

**A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the plan design; however, these materials and any items not covered below may be purchased at preferred pricing from a Blue View Vision Select provider. In addition, benefits are payable only for expenses incurred while the group and insured person's coverage is in force. Combined Offers. Not combined with any offer, coupon, or in-store advertisement; Experimental or Investigative. Any experimental or investigative services or materials; Crime or Nuclear Energy. Conditions that result from: (1) insured person's commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available; Uninsured. Services received before insured person's effective date or after coverage ends; Excess Amounts. Any amounts in excess of covered vision expense; Routine Exams or Tests. Routine examinations required by an employer in connection with insured person's employment; Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if insured person does not claim those benefits; Government Treatment. Any services actually given to the insured person by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if insured person is not required to pay for them or they are given to the insured person for free; Services of Relatives. Professional services or supplies received from a person who lives in insured person's home or who is related to insured person by blood or marriage; Voluntary Payment. Services for which insured person is not legally obligated to pay. Services for which insured person is not charged. Services for which no charge is made in the absence of insurance coverage; Not Specifically Listed. Services not specifically listed in this plan as covered services; Private Contracts. Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act; Eye Surgery. Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery; Sunglasses. Sunglasses and accompanying frames; Safety Glasses. Safety glasses and accompanying frames; Hospital Care. Inpatient or outpatient hospital vision care; Orthoptics. Orthoptics or vision training and any associated supplemental testing; Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power; Lost or Broken Lenses or Frames. Any lost or broken lenses or frames, unless insured person has reached a new benefit period; Frames: Discount is not available on certain frame brands in which the manufacturer imposes a no discount policy.

Anthem

BLUE VIEW VISION SELECT ADDITIONAL SAVINGS

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

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

LASER VISION CORRECTION SURGERY

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

USING YOUR BLUE VIEW VISION SELECT PLAN

The Blue View Vision Select network is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

OUT-OF-NETWORK

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

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

In Indiana: Anthem Blue Cross and Blue Shield is a trade name of Anthem Insurance Companies, Inc. In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc. In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWi collectively underwrite or administer the POS policies. In Missouri: Anthem Blue Cross and Blue Shield is the trade name RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC) and HMO Missouri, Inc. use to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensee of the Blue Cross and Blue Shield Association. ® Blue Cross and Blue Shield are registered marks of the Blue Cross and Blue Shield Association.

Life Insurance Coverage

Life Insurance tier system changing: More opportunities to elect dependent life coverage

State Personnel is excited to announce that beginning this Open Enrollment, you may elect dependent life insurance without being enrolled in supplemental life. This change allows you the opportunity to elect dependent life insurance without enrolling in supplemental. Please keep in mind that you are still required to have basic life insurance to be eligible to apply for supplemental or dependent life.

Also, it is important to note that while child life insurance is guaranteed issue regardless of when the application is made, spouse life requires completing the Evidence of Insurability (EOI) process to acquire or increase the coverage level outside of your new hire election period.

During Open Enrollment, you will be able to decrease your coverage level or drop any of your life insurance plans. You may also update your beneficiary information and/or allocation amounts through your Open Enrollment event. All changes will be effective in January.

Outside of Open Enrollment you may acquire or make changes to your life insurance plans by completing the EOI process at any time throughout the year. Allowable changes include increasing your coverage level and/or adding an eligible spouse to your dependent life insurance plan. This process applies to all three life insurance plans sponsored by the state of Indiana (basic, supplemental and dependent life).

The EOI application can be completed online at any time at www.LifeBenefits.com/SubmitEOI. On average the application takes 10 to 30 minutes to complete. Instructions on how to submit EOI through Securian can be found at www.in.gov/spd/2868.htm. 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. Instruction on how to change your life insurance beneficiaries can be found at www.in.gov/spd/2868.htm. 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 Dec. 31, 2015, are limited to $200,000 of supplemental life insurance coverage. Employees attaining age 65 during the plan year are automatically be reduced to $200,000 of supplemental life insurance coverage and their payroll deductions adjust accordingly.

Note: Minnesota Life Insurance Company is in the process of rebranding their company name to Securian. The name change does not impact your coverage; however, please be aware that you may begin to see communications under the Securian name.

2016 BENEFITS OPEN ENROLLMENT

Take time this Open Enrollment to review and 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 minutes to verify your beneficiary designations and update their contact information in your Open Enrollment event. By routinely checking this information, you are assuring that you have allocated your life insurance benefits as desired since certain life events such as marriage, divorce birth or death may change how you would like your benefits paid out.

In addition to confirming your beneficiary allocation, you should also update their contact information. It is extremely important that 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 was to be processed. Without updated contact information it may take a significantly longer period of time to pay out a claim.

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. 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.

SECURIAN®

Why do I need this insurance?

Group Term Life insurance, underwritten by Minnesota Life Insurance Company, can protect your family's financial future from the unexpected loss of your life and income during your working years.

Life insurance proceeds can be an important tool in helping your family afford final expenses, such as funeral and medical bills, as well as day-to-day financial obligations.

ENROLL IN YOUR GROUP LIFE INSURANCE PROGRAM

Basic coverage

Basic Term Life and Accidental Death & Dismemberment (AD&D)

1.5x annual salary

- Includes matching AD&D benefit
- All coverage is guaranteed if elected within initial eligibility period
- A portion of this coverage paid for by State of Indiana

Additional features

Beyond paying a benefit in the event of your death, your group life insurance has other important features:

- **Accidental Death and Dismemberment (AD&D)** – Provides beneficiaries with additional financial protection if an insured's death or dismemberment is due to a covered accident, whether it occurs at work or elsewhere.
- **Take your coverage with you** – If you are no longer eligible for coverage as an active employee, you may port your Basic and Supplemental Life coverage (portable coverage ends at age 70) or you may convert your life coverage to an individual life insurance policy. Premiums may be higher than those paid by active employees.
- **Early benefit payments if diagnosed as terminally ill** – If an insured person becomes terminally ill with a life expectancy of 12 months or less, he/she may request early payment of up to 100 percent of the life insurance amount, up to a maximum of $1,000,000 (Basic and Supplemental combined).

Bi-weekly cost of coverage

Basic Term Life and AD&D:

$0.113 per $1,000 of salary

Supplemental Term Life

Age	Rate per $1,000
Under 39	$0.048
40-44	0.078
45-49	0.126
50-54	0.194
55-59	0.311
60-64	0.446
65 and older	0.718

Rates increase with age.

Spouse Term Life

Coverage amount	Bi-weekly rate
Spouse only - $5,000	$0.720
Spouse only - $10,000	1.440
Spouse only - $15,000	2.160
Spouse only - $20,000	2.880

Child Term Life

Coverage amount	Bi-weekly rate
Child only - $5,000	$0.450
Child only - $10,000	0.900
Child only - $15,000	1.350
Child only - $20,000	1.800

Spouse and Child Term Life Packages

Coverage amount	Bi-weekly rate
Spouse $5,000/Child $5,000	$1.00
Spouse $10,000/Child $10,000	2.00
Spouse $15,000/Child $15,000	3.00
Spouse $20,000/Child $20,000	4.00

All rates are subject to change.

Here's the easy math to your bi-weekly premium:

Total coverage you need $ _____

÷ 1,000 _____

x your rate $ _____

=

Bi-weekly premium $ _____

Protect your family from the unexpected loss of your life and income during your working years.

Coverage options

You must be enrolled in Basic Term Life and Accidental Death & Dismemberment (AD&D) to elect any of the coverages shown below.

Supplemental Term Life	Spouse Term Life	Child Term Life	Spouse and Child Term Life Packages
$10,000 increments Maximum coverage: $500,000 Any elections or increases require Evidence of Insurability (EOI)	**$5,000, $10,000, $15,000 or $20,000** Any elections or increases require EOI	**$5,000, $10,000, $15,000 or $20,000** All child coverage is guaranteed; EOI is not required Children are eligible from live birth to the end of the month in which they turn 26 years old	Spouse **$5,000**/Child **$5,000** Spouse **$10,000**/Child **$10,000** Spouse **$15,000**/Child **$15,000** Spouse **$20,000**/Child **$20,000** Package elections require the spouse and child to have the same coverage amount If you elect a package, you cannot elect separate Spouse Term Life or Child Term Life coverage amounts Children are eligible from live birth to the end of the month in which they turn 26 years old
ELECT	ELECT	ELECT	ELECT

QUESTIONS?

Visit **http://www.in.gov/spd/2868.htm** or call **317-232-1167** (Indianapolis) or **1-877-248-0007** (outside Indianapolis)

Why Life Insurance?

Learn how life insurance can protect your financial future.

Scan here with your smart phone or tablet, or visit **LifeBenefits.com/videos/Term**, to view a short video about your life insurance program.

Are you a new employee to the State of Indiana?

As a newly eligible employee, you have a one-time opportunity to elect guaranteed coverage – no health questions asked – for you and your family during your initial eligibility period.

The following guaranteed coverage amounts are available:

- Basic Term Life and Accidental Death & Dismemberment (AD&D) – 1.5x annual salary
- Supplemental Term Life – Up to $200,000
- Spouse Term Life – Up to $20,000
- Child Term Life – All coverage is guaranteed

Elections after your initial eligibility period and amounts exceeding the guaranteed issue limit require Evidence of Insurability (EOI).

41% OF RECENT SHOPPERS SAY LIFE EVENTS LIKE

MOTIVATED THEM TO SHOP FOR LIFE INSURANCE.

Source: Life Insurance and Market Research Association (LIMRA), 2013

This is a summary of plan provisions related to the insurance policy issued by Minnesota Life Insurance Company to the State of Indiana. In the event of a conflict between this summary and the policy and/or certificate, the policy and/or certificate shall dictate the insurance provisions, exclusions, all limitations, and terms of coverage. All elections or increases are subject to the actively at work requirement of the policy.

Insurance products are underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. Products offered under policy form series 13-31557 or 02-30428.13.

Securian Financial Group, Inc.

400 Robert Street North, St. Paul, MN 55101-2098
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Group Insurance
www.LifeBenefits.com

Carrier Contact Information

Addresses, phone numbers and websites

Medical
Anthem Insurance Companies, Inc.
P. O. Box 390
Indianapolis, IN 46206
Customer Service: 1-877-814-9709
TDD: 1-800-475-5462
www.anthem.com

Dental
Anthem Dental Complete
Anthem Insurance Companies, Inc.
P.O. Box 390
Indianapolis, IN 46206
TDD: 1-800-475-5462
www.anthem.com

Vision
Anthem Blue View Vision Select
Anthem Insurance Companies, Inc.
P. O. Box 390
Indianapolis, IN 46206
Customer Service: 1-877-254-9443
www.anthem.com

Health Savings Accounts
The HSA Authority
P.O. Box 1454
Fort Wayne, IN 46858
Customer Service: 1-888-472-8697
www.theHSAauthority.com
Employer Code # 100366

Prescriptions Program
Express Scripts
Customer Service: 1-877-841-5241
www.express-scripts.com

Flexible Spending Accounts
Key Benefit Administrators, Inc.
P. O. Box 55210
Indianapolis, IN 46205-0210
Customer Service: 1-800-558-5553
www.keyqualifiedplans.com

Life Insurance
Minnesota Life Insurance Company
400 Robert Street North
St. Paul, MN 55101-2098
Customer Service:
1-866-293-6047
www.LifeBenefits.com

Employee Assistance Program
Anthem EAP
Customer Service: 1-800-223-7723
www.anthemeap.com

Anthem 24/7 NurseLine
1-888-279-5449

Castlight
Web: https://mycastlight.com/stateofindiana/
Phone: 888-920-1264
Email: support@castlighthealth.com

HumanaVitality
Web: https://our.humana.com/investinyourhealth/
Customer Service: 1-800-708-1105

Health and Wellness Center
Indiana Government Center - South
402 W. Washington St., Room W041
Indianapolis, IN 46204
317.963.2035
www.investinyourhealthindiana.com/hawc/

Contact the Benefits Hotline toll-free at 1-877-248-0007 outside of Indianapolis or 317-232-1167 within the Indianapolis area. Benefit specialists are available from 7:30 a.m. to 5 p.m. Monday through Friday, Eastern Standard Time.

You may also email your questions to SPDBenefits@spd.in.gov.

Legal Notices

Eligibility Requirements to Enroll

All active, full-time employees and elected or appointed officials are eligible to participate. For the purpose of benefits eligibility, full-time employees are defined as active employees whose regular work schedule is at least 37½ hours per week. Part-time, intermittent and hourly (temporary) employees who worked an average of thirty (30) or more hours per week over a 12-month review period would also be eligible for benefits. Part-time, intermittent and hourly (temporary) employees working less than thirty (30) or more hours per week over a 12-month review period are not eligible for insurance or related benefits.

Dependents of eligible employees may be covered under the State's benefit plans. In order for dependents to be covered, the employee must be covered.

(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.

Please Note: As of the 2016 benefit plan year, Anthem will administer the disabled dependent verification process. You must contact Anthem at least 45 days prior to the end of the month in which a disabled dependent turns 26 in order to initiate the eligibility review process and ensure that there is no lapse in coverage. Failure to contact Anthem will result in automatic removal. Anthem will request verification of disability for your dependent(s) in early 2016 in order to determine eligibility to continue coverage under your health plan(s).

If you have questions or concerns about dependent coverage, please feel free to contact State Personnel at 1-877-248-0007 outside the 317 area code or 317-232-1167 locally.

Qualifying Events

Qualifying events allow for changes

After noon (EST) on Wednesday, Nov. 18, you are not able to make changes to your benefits. This means you must be certain you have elected the coverage that is right for you and added all eligible dependents who 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. 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 and complete any necessary paperwork within 30 calendar days from the date of the qualifying event, you will not be 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.

Dual Coverage

Dual coverage is not allowed under any 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 will have the choice to continue your retiree coverage and waive your active employee coverage, or vice versa. However, you will not be permitted to carry state retiree insurance and active state employee coverage simultaneously. Dual coverage is only permitted for dependent life.

Creditable Coverage Disclosure Notice

Important Notice from Indiana State Personnel Department About Your Prescription Drug Coverage and Medicare

You are receiving this notice because you or a family member may be eligible for or currently enrolled in Medicare. However, if you are not enrolled in Medicare, you may disregard this notice. If you enroll in Medicare at a later date, please be sure to review this document.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with a State of Indiana employee group pharmacy benefit plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can getthis coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like anHMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standardlevel of coverage set by Medicare. Some plans may also offer more coverage for a higher monthlypremium.
2. The State of Indiana's Third Party Administrators determined that the prescription drug coverage offered byExpress Scripts is, on average for all plan participants, expected to pay out as much as standard Medicareprescription drug coverage pays and is therefore considered Creditable Coverage. Because your existingcoverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) ifyou later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan and still meet the eligibility for the State of Indiana health plan, your current employee coverage will not be affected. You may continue your State of Indiana employee coverage and elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current State of Indiana employee health plan that includes prescription drug coverage, be aware that you and your dependents may not be able to enroll in the State's plan except during an open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the State of Indiana health plan that includes prescription drug coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage:

Contact the Benefits Division for further information at 317-232-1167 or outside the 317 area code, 877-248-0007. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the State of Indiana changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug

coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the"Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

October 8, 2015

Indiana State Personnel Department
Benefits Division
402 W. Washington Street, W161
Indianapolis, IN 46204
317-232-1167 local, or
877-248-0007 outside the 317 area code

- View the notice posted on our Open Enrollment website

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 "especial 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, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf
Medicaid Customer Contact Center: 1-800-221-3943

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

Legal Notices

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/id_006254
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://medicaid.mt.gov/member
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

GEORGIA – Medicaid
Website: http://dch.georgia.gov/
- Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.state.pa.us/hipp
Phone: 1-800-692-7462
RHODE ISLAND – Medicaid

Website: http://www.eohhs.ri.gov/
Phone: 401-462-5300

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

Legal Notices

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

OMB Control Number 1210-0137 (expires 10/31/2016)

Women's Health and Cancer Rights Act (WHCRA) 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:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and the patient.

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

HIPPA Notice of Special Enrollment Rights

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

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

Newborns' and Mothers' Health Protection Act of 1996

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

View the **Notice of Privacy Practices** and the **Uniformed Services Employment and Reemployment Rights Act (USERRA)** document linked on the Open Enrollment website.

Glossary

Carrier/vendor fair
An event where representatives from plan providers are available to answer questions about coverages provided by their plans.

Claim
Request for payment that the member or their health care provider submits to the health insurer, when services or supplies believed to be covered are provided.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
Federal law that allows you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee or another qualifying event.

Co-insurance
Percentage of allowed charges for covered services a member is required to pay after the deductible has been met and up to the out-of-pocket maximum. For example, health insurance may cover 70% of charges for particular service; the member is responsible for the remaining 30%. In this example the 30% is the co-insurance.

Consumer-Driven Health Plan (CDHP)
Health insurance plan which encourages members to become actively involved in making their own healthcare decisions (i.e., selecting healthcare providers with the lowest cost and highest quality, when receiving services and managing their own fitness and wellness). This type of plan features higher deductibles compared to that of what is known as traditional insurance plans. CDHPs can be paired with a health savings account (HSA) to allow a member to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

Deductible
Dollar amount an employee must pay for medical and prescription services before their health insurance plan begins to pay. This amount varies based upon the plan and coverage level chosen by the employee. These costs can be covered pre-tax by the funds in a HSA if the health plan is a CDHP. Otherwise, they are paid by the employee's personal financial means.

Dependent(s)
(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.

Please Note: As of the 2016 benefit plan year, Anthem will administer the disabled dependent verification process. You must contact Anthem at least 45 days prior to the end of the month in which a disabled dependent turns 26 in order to initiate the eligibility review process and ensure that there is no lapse in coverage. Failure to contact Anthem will result in automatic removal. Anthem will request verification of disability for your dependent(s) in early 2016 in order to determine eligibility to continue coverage under your health plan(s).

Dependent Care (Flexible Spending Account)
FSA established to pay for certain expenses to care for the dependents of an employee while working (married spouse must be employed as well). While this most commonly means child care, for children under the age of 13, it can also be used for children of any age who are physically or mentally incapable of self-care. It can additionally be used for adult day care for senior citizen tax dependents who reside with the employee, such as parents or grandparents. The maximum annual contribution limit is $5,000.

Dual coverage
Enrollment of a member in more than one State-sponsored insurance plan with the same type of benefits. The state does not allow its employees to have dual coverage.

Employer contribution
Fees paid by an employer toward the cost of its employees' coverage.

Enrollee/subscriber/member
With the state of Indiana, the employee is the enrollee.

Enrollment
Process by which an employee chooses the insurance plans/coverage that best meets their needs. State employees do this online through the PeopleSoft system.

Glossary

Exclusion
Specific listed services or circumstances that are defined in the insurance contract for which benefits will not be provided.

Explanation of Benefits (EOB)
Statement provided to the member by the health insurance plan explaining the benefit calculations and payment of medical services. It details services rendered and benefits paid or denied for each claim submitted. An EOB lists the charges submitted, amount allowed, amount paid and any balance possibly owed as the patient's responsibility.

Family coverage
An employee and at least one eligible dependent enrolled in an insurance plan.

Family and Medical Leave Act (FMLA)
Federal law that guarantees up to 12 weeks of job-protected leave for employees if they need to take time off due to serious illness or disability, have/adopt a child or to care for another family member.

Family status change/qualifying event
Personal change in status which may allow an employee to modify their benefit elections.

Examples are, but not limited to, the following:

1. Change in legal marital status – marriage, divorce, legal separation, annulment or death of a spouse
2. Change in number of dependents – birth, death, adoption, placement for adoption, award of legal guardianship
3. Change in employment status of the employee's spouse or employee's dependent – switching from part-time to full-time employment status or from full-time to part-time, termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence which results in employee/dependent becoming ineligible for coverage
4. Dependent satisfies or ceases to satisfy eligibility requirement – such as attainment of the limiting age. See DEPENDENT.

Qualifying events are defined by the IRS and must be reported to the Benefits Hotline within 30 calendar days of the event occurring.

Flexible Spending Account (FSA)
Account offered to employees which allow a fixed amount of pre-tax money to be set aside for qualified medical expenses. That amount must be determined in advance and employees pay it back over the course of the 26 pay periods of the calendar year. Any money not spent out of the account by the end of the calendar year is lost to the employee. The maximum annual contribution limit is $2,500.

Formulary
A list of medications that are approved to be prescribed under a prescription drug plan. The development of formularies is based on evaluations of efficacy, safety and cost-effectiveness.

Front-load (HSA)
Initial contribution the state makes into an employee's HSA. The state front loads approximately 50% of its annual contribution commitment into the employee's HSA at the beginning of each calendar year. The remainder of the contribution is divided among the remaining 26 pay periods. See HEALTH SAVINGS ACCOUNT or further information.

Health Insurance Portability and Accountability Act (HIPAA) of 1996
Designed to streamline all areas of the health care industry and to provide additional rights and protections to participants in health plans.

Health Savings Account (HSA)
Account created for employees covered under a CDHP to save for medical expenses with pre-tax contributions, made by the state and can be made by the employee. Contributions can also be made by third parties. If an employee chooses to contribute to the HSA, that money is deducted from their pay check on a pre-tax basis. The amount that the employee contributes can be changed at any time throughout the year by contacting the Benefits Hotline. The maximum contribution limit for a HSA paired with a single coverage CDHP is $3,350; for family coverage, the limit is $6,650. This includes contributions from the state, the employee and any third-part contributions. Employees 55 and older may make an additional $1,000 catch-up contribution until they enroll in Medicare. The money in the HSA can be used to pay for qualified medical expenses, which include most medical care such as dental, vision and prescription drugs. Any money not spent out of the account by the end of the calendar year rolls over and remains in the account until it is spent. If the money in an HSA is used for anything other than qualified medical expenses, it can become a taxable event. Eligible medical expenses are defined by the IRS and can be found in Publication 929.

Immunizations
Vaccines against certain diseases, which can be administered either orally or by injection (i.e., flu shots).

In-network
Healthcare providers who contract with the insurance plan to provide services at a discounted rate.

Limited Purpose Medical Spending Account (Flexible Spending Account)
If someone has an HSA and elects to have a Flexible Spending Account (FSA), the FSA becomes a Limited Purpose Medical Spending Account. Expenses under the Limited Purpose Medical Spending Account are limited to:

- Dental care services/treatments,
- Vision care services/treatments,
- Preventive care services - limited to diagnostic procedures and services or treatment taken to prevent the onset of a disease or condition that is immediately possible. This

does not include services/treatments to treat an existing condition. A diagnosis or letter of medical necessity may be required to consider claim reimbursement. See also Flexible Spending Account

Mail order pharmacy
Alternative to retail pharmacies, members can order and refill prescriptions via mail, Internet, fax or telephone in 90-day quantities. Prescriptions are mailed directly to the member's home. All state health insurance plans cover mail order pharmacy through Express Scripts or the pharmacy benefit provider.

Maintenance drug
Medication anticipated to be taken on an ongoing basis for at least several months to treat a chronic condition such as diabetes, high blood pressure, asthma, etc.

Medical Flexible Spending Account
See *Flexible Spending Account*

Member
Eligible individual enrolled in an insurance plan; member may be the employee or any dependent.

Network
Group of medical professionals contracted to provide services to members of a health insurance plan.

Non-Tobacco Use Incentive
Agreement to which an employee commits and signs (electronically) to not use tobacco for the benefit year and agrees to random tobacco testing. The incentive is only available to employees enrolled in medical coverage.

If an employee accepts the Non-Tobacco Use Incentive and later uses tobacco, that employee will be terminated. The only exception to the job loss penalty is if the employee revokes the agreement by logging in to PeopleSoft and completing the self-service process to revoke their agreement prior to the use of any tobacco product.

Open Enrollment
Specific time of year when employees can enroll in state-offered benefits.

For benefit year 2016, open enrollment is Oct. 28 through noon Nov. 18 (EST). Changes you make during Open Enrollment take effect Jan. 1, 2016.

Out-of-pocket costs
Expenses for medical care that are not reimbursed by insurance. This includes all deductibles and co-insurance paid under the insurance plan. Costs can be covered pre-tax by the funds in a HSA if the health plan is a CDHP or FSA. Otherwise they are paid by the member's personal financial means.

Out-of-pocket maximum
Limit set on each insurance plan that caps the maximum a member has to pay for medical services during a calendar year. This includes all deductibles and co-insurance paid under the insurance plan. These costs can be covered pre-tax by the funds in a HSA if the health plan is a CDHP or FSA. Otherwise they are paid by the member's personal financial means. Premiums do not count toward out-of-pocket maximums. Employees must still pay premiums, even if they meet their out-of-pocket maximum.

Participating provider
Individual physicians, hospitals and professional health care providers who have a contract to provide services to a network's members at a discounted rate and to be paid directly for covered services. See *Network.*

Prior-authorization
Approval required for specifically designated procedures or hospital admissions. When care is received in-network, the primary care physician or specialist is usually responsible for obtaining pre-authorization. For out-of-network services, the member is responsible for obtaining pre-authorization.

Premium
Amount each employee pays for an elected health plan.

Prescription medication
FDA-approved medicine regulated by legislation to require a medical prescription before it can be obtained.

Preventive care/services
Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Services are covered 100% by all insurance plans by law (i.e. annual physicals, well baby visits, flu shots, etc.).

Provider
Person, organization or institution licensed to provide health care services.

Self-insurance
Practice of an employer that assumes complete responsibility for losses, which might be insured against, such as health care expenses. In effect, self-insured groups have no real insurance against potential losses and instead maintain a fund out of which is paid the contingent liability subject to self-insurance. The state is self-insured.

Termination of Coverage Date
The actual date the coverage ceased.

Webinar
Short for web-based seminar; a presentation, lecture, workshop or seminar that is transmitted over the Internet.

Wellness program
Health management program which incorporates the components of disease prevention, medical self-care and health promotion.

Castlight puts everything in one place for you.

Healthcare shouldn't be complicated. Castlight makes it simple: Even when you're sick, it's easy to find a doctor, locate a lab, and check your medical bills in one convenient location.

Find care
Find doctors, specialists, hospitals and more.

Shop
Compare doctors side by side, looking at prices and patient reviews.

View claims
Review your medical claims and understand what you paid and why.

Track spending
See how much you and your family have spent on care.

Tips
Get tips on how to make the most out of your healthcare.

Visit your healthcare one-stop shop at www.mycastlight.com

24/7 NurseLine

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

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

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

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

24/7 NurseLine strives to:

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

Anthem BlueCross BlueShield

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

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWi), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (Compcare), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

EANSH1283A Rev. 8/11 F0011166

If you have a serious injury or health issue,

We're here when you need us most

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

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

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

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

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

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

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

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

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

Case Management's high satisfaction scores

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

*2008 member satisfaction study.

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ConditionCare

Staying healthy and "making it work"

ConditionCare supports employees with chronic conditions

More than 75% of health care costs are due to chronic conditions. And poor lifestyle habits may complicate these health problems.

With ConditionCare, members get personalized, one-on-one support straight from a nurse to help them better manage chronic conditions. They also get information and tools to help them avoid unnecessary emergency room visits, hospital stays and time away from the job. It's the expert guidance people need to live healthier with a long-term health condition.

ConditionCare helps employees deal with:

- Asthma
- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease
- Heart failure

ConditionCare Nurse Care Managers are supported by a team of dietitians, social workers, pharmacists, health educators and other health professionals. They work with members to help them:

- Understand their condition.
- Avoid health complications.
- Follow their doctor's orders and take their medicine properly.
- Adopt healthier behaviors to better manage their condition.
- Answer questions between doctor visits.
- Coordinate their care.
- Get help for depression, if needed.

A personal "blueprint" for health

The Nurse Care Manager typically starts with a quick health assessment to find health risks and tailor the program to best meet the member's needs. Based on those results and the doctor's plan of care, a personalized Health Chart is created with member specific goals and action steps. The Nurse Care Manager will be there from start to finish to help the member make healthy changes.

Ninety-one percent of members who spoke to a Nurse Care Manager gave an excellent rating to their ConditionCare experience.[1]

ConditionCare reports a return on investment of at least $2:$1 or better.[2]

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1 Internal Health and Wellness Solutions Member Satisfaction Study (high-risk participants). Q3 2013.
2 Internal Health and Wellness Solutions data study and Actuarial validation. 2009.

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EANSH1285A Rev. 04/14

Improve your health now

ConditionCare: vascular at-risk

Healthier today, better tomorrow

Do you want to get on the right track with your health? Now is a great time to do it!

Your vascular health is important in maintaining a good quality of life and to keep doing what you love. ConditionCare can help you take care of symptoms tied to high cholesterol, high blood pressure or metabolic syndrome.

If one or more of these conditions is out of control or if you're overweight, your risk may be higher of having other health problems such as heart disease or diabetes

Call us toll free at 888-279-5449 to join the program. It's in addition to your benefits for you or your covered family members. When you join, you'll get:

- 24-hour, toll free access to a nurse who'll answer your questions. You also can get help making lifestyle changes that may improve your health.
- A health screening and support from health professionals to help you reach your health goals.
- Educational guides and tips to help you learn more about your condition.

We may call to find out if ConditionCare can help you and sign you up. For your protection, we'll verify your address or date of birth before talking about your health.

Get closer to your goals

To learn more or to join ConditionCare, call us toll free at 888-279-5449.

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MINSH1309A Rev. 12/13

Manage bone, joint and muscle pain

ConditionCare: musculoskeletal

Our nurse care managers are here to help you

Did you know that almost one in two people in the U.S. has trouble moving due to body aches, pains and injuries?[1] For many people, joints and the tissues that connect them (musculoskeletal system) have grown stressed. That can happen in many ways – playing sports, exercise, car accidents, illness, even an unhealthy diet.

Healthy bones and joints are important for everyone. But most people don't think about them until something goes wrong.[2]

But there's good news. If you or a covered family member has this kind of pain, you can join the **ConditionCare** program. Just call us toll free at 888-279-5449. When you join, you'll get:

- Counseling and coaching on eating well.
- An exercise plan for your exact goals.
- Round-the-clock phone access to a nurse care manager for support and information.

ConditionCare is in addition to your health plan. It doesn't cost you or your covered family members anything extra to use.

We may call to find out if **ConditionCare** can help you and ask you to sign up. For your protection, we'll verify your address or date of birth before talking about your health.

Anthem BlueCross BlueShield

Get help managing your condition

To learn more or to join ConditionCare, call us toll free at 888-279-5449.

Sources:
1 Bone and Joint Initiative U.S.A. website: *Facts & Figures* (accessed March 2014): usbjd.org.
2 U.S National Library of Medicine website: *Bone Health Basics* (accessed March 2014): nlm.nih.gov.

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MINSH1307A Rev. 12/13

Anthem's cancer resources

Support throughout your health care journey with cancer

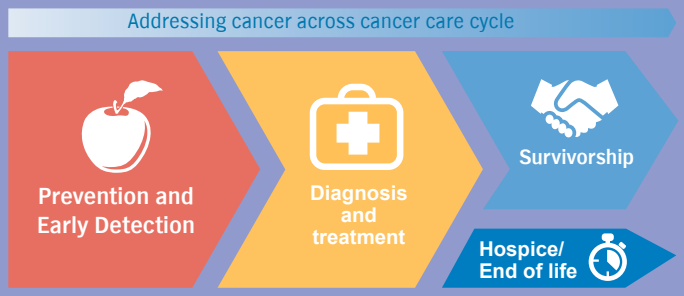
Wondering what you can do to prevent cancer? Have you or someone you love been told you have cancer? A cancer diagnosis can be scary. It can create confusion and disrupt your life and the lives of your loved ones. You may have questions such as:

- What treatment do I need?
- Who provides the right treatment?
- What will my life be like having cancer?
- When will I feel better?

That's why we're here to partner with you to support cancer prevention or through your cancer journey by offering helpful resources and services. As a member you have access to a large network of providers and centers specializing in cancer treatment.

How can I find cancer resources and programs?

For more information about Anthem's cancer resources, go to anthem.com. Select the Health and Wellness tab on the top of the webpage. Here you'll find information on prevention and wellness topics including:



Prevention, screenings, vaccines and wellness – Diet, lifestyle and prevention are important to promote optimal health. Cancer prevention screenings are important, which is why we cover a variety of cancer screenings.

Diagnosis and treatment – For those who have been told they have cancer or going through cancer treatment, we offer programs including: Case Management, Employee Assistance (if available) and the Help for Caregivers online resource.

Case management services

Case management gives you access to a licensed health professional who offers support, education and resources from diagnosis through treatment and recovery. Your policy has a benefit for case management services. Case management is provided by a licensed health professional, often an RN, who can help you and your family:

- Understand how your benefits will support treatment and medications.
- Understand what questions to ask and how to best work with your doctor.
- Know what to expect during the treatment and post-treatment process.
- Navigate the insurance system, as needed.
- Identify resources and support where you live.

Post-treatment – While most members move through their cancer treatment and into a cancer-free life, sometimes they must deal with end-of-life issues. We can help with both of these paths. Our services include Journey Forward, a program designed to improve the long-term health of cancer survivors. We also provide hospice benefits and end-of-life care for members facing a terminal illness.

Contact us today if you are interested in Case Management services. You can use the customer service e-mail through your registered account at anthem.com, call the customer service number on the back your ID card or we may contact you.

Having cancer doesn't mean you're on your own. We're here to support you and your health.

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Getting care when you need it now

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

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

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

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

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

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

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

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

Before you go

Call the office or clinic and ask:

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

Average cost

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

*Deductibles and coinsurance apply.

Emergency room rule of thumb

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

Want more information on ER alternatives?

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

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

Anthem®

Health. **Join In.**℠

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

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

Deciding where to go when you need care right away

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

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

*Deductibles and coinsurance apply.

Let a nurse help you decide

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

Wondering where to go?

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

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

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Sometimes it's good to talk things out.

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

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

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

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

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

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

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

Your privacy matters

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

Invest In Your Health

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Take care of yourself. Use your preventive care benefits.

Anthem BlueCross BlueShield

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

Our health plans offer the services listed in this preventive care flier at no cost to you.[1] When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing them. That's diagnostic care.

Child preventive care

Preventive physical exams

Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Counseling for those ages 10–24, with fair skin, about ways to lower their risk for skin cancer
- Screening and behavioral counseling for tobacco use
- Vision screening[2] when done as part of a preventive care visit

Immunizations:

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

Women's preventive care

- Well-woman visits
- Breast cancer, including exam, mammogram, and, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met[3]
- Breast-feeding: primary care intervention to promote breast-feeding support, supplies and counseling (female)[4,5]
- Contraceptive (birth control) counseling
- FDA-approved contraceptive medical services provided by a doctor, including sterilization
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening[5]
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV[5]
- Pelvic exam and Pap test, including screening for cervical cancer

The preventive care services listed are recommendations as a result of the Affordable Care Act (ACA, or health care reform law). The services listed may not be right for every person. Ask your doctor what's right for you, based on your age and health condition(s).

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

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Adult preventive care

Preventive physical exams

Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and CT colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test for vision[2]
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years[6]
- Screening and counseling for obesity
- Prostate cancer, including digital rectal exam and PSA test
- Sexually transmitted infections: related screening and counseling
- Screening and behavioral counseling for tobacco use
- Violence, interpersonal and domestic: related screening and counseling

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- Measles, mumps and rubella (MMR)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)
- Zoster (shingles) for those 60 years and older

1 The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your *Certificate of Coverage* or call the Customer Care number on your ID card.

2 Some plans cover additional vision services. Please see your contract or *Certificate of Coverage* for details.

3 Check your medical policy for details.

4 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.

5 This benefit also applies to those younger than 19.

6 You may be required to get prior authorization for these services.

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Anthem BlueCross BlueShield

Get healthy. Stay healthy.

Get your health checked today

We have you covered

Preventive exams can help you get and stay healthy

When your body changes as you get older, you want to understand those changes and how they affect your health. That's what preventive exams do for you. They give your doctor a snapshot of your health. And they give you a chance to talk to your doctor and see if you need to make any changes. They also keep your doctor updated about your health so you can get better care if problems come up later.[1]

Get ready before your exam and know more coming out of it

It's helpful for both you and your doctor if you find out a few things about your health ahead of time. Before your visit, write down things like:[2]

- Your health history and your family's, especially if anything has changed since your last visit
- Any medicines you take, how much and how often (include vitamins and over-the-counter drugs)
- Concerns you have about your health
- Any symptoms you're having

MANSH0314ABS Rev. 06/14

Don't forget these important screenings

The U.S. Preventive Services Task Force recommends these screenings to help you stay healthy.[3,4] Your doctor may suggest other tests or more frequent tests, depending on your risk factors. Some of those risk factors include your age and family history, which could make you more likely to get an illness.

Screening	How often?
Blood pressure	At least every two years for adults 18 and older
Cholesterol	Regular screenings beginning at age 35 for men and 45 for women (younger if you smoke, have diabetes, high blood pressure or a family history of heart disease)
Skin exam	Self-exams at least once a year; talk to your doctor about screening for skin cancer (especially if you are fair-skinned or spend a lot of time outside)
Diabetes	Regular tests if you have high blood pressure or high cholesterol; talk to your doctor about other reasons you may need to be tested

Women

Screening	How often?
Mammogram	Every one to two years for women 40 and older, with or without a breast exam
Pap test	Every one to three years for sexually active women between the ages of 21 and 70
Osteoporosis	Routine screening starting at age 65 (age 60 for women with risk factors like a small frame or weight under 155 pounds)
Chlamydia	Routine screening for sexually active women who are 25 and younger; talk to your doctor about tests for other illnesses that spread through sex

Men

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

What's the difference between preventive care and diagnostic care?

Did you know that there are tests that can help you stay healthy, catch any problems early on and even save your life? These tests are called preventive care because they can help prevent some health problems. They're different from diagnostic tests, which help diagnose a health problem. Diagnostic tests are given when someone has symptoms of a health problem and the doctor wants to find out why.

It's important to know the difference between preventive tests and diagnostic tests. For example, if your doctor wants you to get a colonoscopy (a test that checks your colon) because of your age or because your family has a history of colon problems, that's called preventive care. But, if your doctor wants you to get a colonoscopy because you're having symptoms of a problem, like pain, that's called diagnostic care.

What to expect

Most preventive exams start with a talk about your health history and any problems. After that, most doctors will talk to you about things like:[2]

- Medicines you take
- How you eat — and how you could eat better
- How physically active you are — and whether you should be more active
- Stress in your life or signs of depression
- Drinking, smoking and recreational drug use
- Safety measures like wearing your seat belt and using sunscreen
- Your sexual habits and any risks they pose
- Tests and vaccines you may need

For more information, visit anthem.com. Under the *Health & Wellness* tab, select **View All Preventive Health Guidelines** at the lower right corner of the screen.

1 Centers for Disease Control and Prevention website: *Regular Check-Ups are Important* (accessed June 2014): cdc.gov/Family/checkup/index.htm.
2 Centers for Disease Control and Prevention website: *Check-Up Checklist: Things to Do Before Your Next Check-Up* (accessed June 2014): cdc.gov/Family/checkuplist/index.htm.
3 Agency for Healthcare Research and Quality website: *Women: Stay Healthy at Any Age* (accessed June 2014): ahrq.gov/patients-consumers/prevention/lifestyle/healthy-women.html.
4 Agency for Healthcare Research and Quality website: *Men: Stay Healthy at Any Age* (accessed June 2014): ahrq.gov/patients-consumers/patient-involvement/healthy-men/healthy-men.html.

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