



# The Torch

The official newsletter for Indiana state employees

## Open Enrollment 2018

### Enroll online starting Oct. 25

This *special edition* is dedicated to 2018 Open Enrollment. Please review all the enclosed information concerning your health care coverage. During this period, you can choose to make additions or changes to your benefit selections. All Open Enrollment communications, including carrier information, rates and plan summaries, are posted on the OE 2018 website: [www.in.gov/spd/openenrollment](http://www.in.gov/spd/openenrollment).

*This Open Enrollment information does not apply to conservation officers, excise officers, Indiana State Police plan participants, or contractors.*

## Eligibility for the state's benefit plans

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

For the purpose of benefits eligibility, full-time employees are defined as active employees whose regular work schedule is at least 37½ hours

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

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*The Torch* is published monthly by the Indiana State Personnel Department and is available online at [in.gov/spd/2540.htm](http://in.gov/spd/2540.htm).

## Looking for plan rates?

The plan rates for 2018 are posted on the Open Enrollment website at [www.in.gov/spd/3141.htm](http://www.in.gov/spd/3141.htm). You can also download the [complete rate chart](#) there.

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## Checklist

# Review the 2018 Open Enrollment checklist

For 2018, there are new rates for the medical plan. A number of resources are available to help you estimate your 2018 expenses, compare plans and become a more informed consumer. Use this checklist to help guide you through the steps to a successful Open Enrollment:

- Educate yourself about changes occurring January 1, 2018.
- Access your HR PeopleSoft account.
- Confirm or update your personal information, including your home and/or mailing address, e-mail address, phone number and ethnic group.
- If you wish to drop your insurance coverage you need to select "waive."
- If you are eligible for the 2018 Wellness CDHP, you need to select this option to enroll in the plan if you are not covered under the 2017 Wellness CDHP.
- If you are enrolled in the 2017 Wellness CDHP, but do not qualify for the 2018 Wellness CDHP, your plan defaults to CDHP 1 unless you make a new selection.
- Review your eligible dependents and beneficiaries.
  - You need to enroll all eligible dependents in each benefit plan you choose.
  - Make sure you remove ineligible dependents from all of your benefit plans and report their eligibility change to the Benefits Hotline.
  - Update personal information for each dependent and/or beneficiary (information must match what is on their social security card).
  - Add your dependent social security numbers.
  - For dependent/beneficiary name changes and Social Security corrections, please contact the Benefits Hotline.
- Check your current elections or make new elections. It is important that you review the dependents enrolled on each of your plans.
- If you have a Health Savings Account (HSA), you need to enter your annual contribution amount. Otherwise it will default to \$0.
- If you have a Flexible Spending Account (FSA), you need to re-elect or re-state your annual contribution amount.
- Accept or decline the Non-Tobacco Use Agreement for 2018.
- Be sure to print an Election Summary after you have submitted your elections.
- If you have any questions regarding your benefits, please contact the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007 (if outside of the Indianapolis area).



## Help sessions are available

For 2018 plan summaries, rates, PeopleSoft instructions and other Open Enrollment information, please log on to [www.in.spd/openenrollment](http://www.in.spd/openenrollment).

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

- Oct. 25 to Oct. 27: 8 a.m. to noon
- Oct. 30 to Nov. 3: noon to 4 p.m.
- Nov. 6 to Nov. 14: 9 a.m. to 3 p.m.
- Wed., Nov. 15: 9 a.m. to noon

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

- **317-232-1167 (in Indianapolis)**
- **Toll-free 877-248-0007**
- **E-mail: [SPDBenefits@spd.in.gov](mailto:SPDBenefits@spd.in.gov)**

## Effective dates

# When do my 2018 Open Enrollment changes take effect?

Health, dental and vision changes/enrollments:

- Effective: January 1, 2018
- First Deduction: December 27, 2017 (1 day of 2017 rates; 13 days of 2018 rates)

Flexible Spending Account (FSA) and Health Savings Account (HSA)

- changes/enrollments:
- Effective: January 1, 2018
  - First Deduction: January 10, 2018

Life insurance changes/enrollments:

- Effective: January 14, 2018
- First Deduction: January 10, 2018

For direct bill agency employees, your benefits will be effective January 1, 2018.  
For deduction information, please see your agency's Payroll Department.

## Know your health plan options: 2018 changes

The state is offering four statewide medical plans for 2018: 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 National (BlueCard) PPO network with Anthem and have a prescription drug plan through CVS Caremark. Each plan has differences in premium costs, deductibles and out-of-pocket maximums.

Please note, in order to be eligible to enroll in the 2018 Wellness CDHP you must have reached an Earned Status of Silver in Go365 on August 31, 2017. This means all points were processed and posted to your Go365 account by the August 31 deadline. If you qualify for the Wellness CDHP and wish to enroll in the plan for 2018, you must select this option within your Open Enrollment event. You are not automatically enrolled in the plan unless you are enrolled in the Wellness Plan for the 2017 plan year. If you are enrolled in the 2017 Wellness CDHP but do not qualify for the 2018 Wellness CDHP, your coverage automatically switches to CDHP 1, unless you actively

|                               | Wellness CDHP | CDHP 1  | CDHP 2  | Traditional PPO                  |
|-------------------------------|---------------|---------|---------|----------------------------------|
| <b>Deductible</b>             |               |         |         | <b>In-Network/Out of Network</b> |
| Single                        | \$2,500       | \$2,500 | \$1,500 | \$750 / \$1,500                  |
| Family                        | \$5,000       | \$5,000 | \$3,000 | \$1,500 / \$3,000                |
| <b>Out-of-Pocket Maximum*</b> |               |         |         |                                  |
| Single                        | \$4,000       | \$4,000 | \$3,000 | \$3,000 / \$6,000                |
| Family                        | \$8,000       | \$8,000 | \$6,000 | \$6,000 / \$12,000               |
| - individual embedded         | \$7,350       | \$7,350 | N/A     | N/A                              |
| <b>Co-insurance</b>           |               |         |         |                                  |
| In-Network                    | 20%           | 20%     | 20%     | 30%                              |
| Out-of-Network                | 40%           | 40%     | 40%     | 50%                              |

elect another plan.

### Family Out-of-Pocket Changes for Wellness CDHP and CDHP 1

The individual embedded out-of-pocket maximum for the family Wellness CDHP and CDHP 1 changes in 2018 from \$7,150 to \$7,350. The individual embedded out-of-pocket maximum saves families

money by limiting the cost spent on any one person to \$7,350. Once a family member meets the individual embedded out-of-pocket maximum, all claims incurred by that family member are 100 percent paid by the plan. The other family members on the plan continue to pay the coinsurance amounts for any claims they incur until the family out-of-pocket maximum of \$8,000 is reached.

## 2018 health plan comparison maximum exposure calculations

| With an HSA                 | Single Coverage |              |            |             | Family Coverage |              |              |             |
|-----------------------------|-----------------|--------------|------------|-------------|-----------------|--------------|--------------|-------------|
|                             | Wellness CDHP   | CDHP 1       | CDHP 2     | PPO         | Wellness CDHP   | CDHP 1       | CDHP 2       | PPO         |
| Annual Employee Premium     | \$461.76        | \$820.56     | \$3,127.80 | \$9,026.16  | \$1,467.96      | \$2,516.28   | \$9,016.80   | \$25,627.68 |
| Maximum Out-of-Pocket Cost  | \$4,000         | \$4,000      | \$3,000    | \$3,000     | \$8,000         | \$8,000      | \$6,000      | \$6,000     |
| State Paid HSA Contribution | (\$1,251.12)    | (\$1,001.52) | (\$599.04) | N/A         | (\$2,502.24)    | (\$2,003.04) | (\$1,198.08) | N/A         |
| Total Exposure              | \$3,210.64      | \$3,819.04   | \$5,528.76 | \$12,026.16 | \$6,965.72      | \$8,513.24   | \$13,818.72  | \$31,627.68 |
| Without an HSA              |                 |              |            |             |                 |              |              |             |
| Annual Employee Premium     | \$461.76        | \$820.56     | \$3,127.80 | \$9,026.16  | \$1,467.96      | \$2,516.28   | \$2,516.28   | \$25,627.68 |
| Maximum Out-of-Pocket Cost  | \$4,000         | \$4,000      | \$3,000    | \$3,000     | \$8,000         | \$8,000      | \$6,000      | \$6,000     |
| Total Exposure              | \$4,461.76      | \$4,820.56   | \$6,127.80 | \$12,026.16 | \$9,467.96      | \$10,516.28  | \$15,016.80  | \$31,627.68 |

Footnote: A) Examples assume employee takes advantage of the Non-Tobacco Use Incentive  
 B) Examples assume costs are incurred within the Anthem provider network

## New Prescription Vendor for 2018: CVS Caremark

The Indiana State Personnel Department is pleased to announce that as of January 1, CVS Caremark will be the new prescription benefit manager. If you are enrolled in medical insurance, your prescription coverage will automatically transfer to CVS Caremark. Although the prescription benefit manager has changed, the prescription benefit copay and coinsurance tier design will remain the same.

### What Does This Change Mean To You?

Under CVS Caremark, you will have a large network of participating retail pharmacies to choose from. There is no requirement for you to switch to a CVS pharmacy. However, as an added benefit, 90 day supplies will now be offered both through mail service and CVS Pharmacies. For a full list of in-network pharmacies, please visit [www.caremark.com](http://www.caremark.com) in December.

One of the most substantial benefits

you will see with the transition to CVS Caremark is the introduction of point-of-sale (POS) rebates to members. CVS Caremark negotiates with the drug companies to establish rebates for certain drugs. For example, a drug may have a list price of \$250 with a rebate of \$100. In the past, you would have been responsible for the full \$250 until your deductible was met. However, with the new point-of-sale rebates, you will only be responsible for paying \$150 at the time you pick up your prescription. In this example, you would save \$100. Not only do POS rebates save you money, they also make prescription purchases more transparent.

The easiest way to manage your prescriptions is through CVS Caremark's website or mobile app. Within both platforms, you may review your mail order prescription, check drug costs and coverage, find a network pharmacy and keep track of your prescription spending. You may

also transfer a current prescription or submit a new one by simply submitting a picture of the prescription label or written prescription. For additional ease, you can even enroll in automated refills. To get started, all you need to do is register at [Caremark.com](http://Caremark.com) and download the CVS Caremark mobile app beginning in December.

CVS Caremark and Indiana State Personnel are working hard to make this transition as smooth as possible. As part of the change, CVS Caremark is collaborating with Express Scripts to transfer your existing prescription(s) so you will not need a new prescription(s) from your doctor. Notifications will be sent in early November to anyone who has a prescription that cannot be transferred along with any prescriptions that will no longer be covered or will be switching prescription tiers.

Below is a quick look at the 2018 prescription coverage.

| Prescription Drug                  | Wellness CDHP  |  | CDHP 1   |  | CDHP 2   |  | Traditional PPO                                      |  |
|------------------------------------|--|--|--|--|--|--|--|--|
|                                    | CVS Caremark Retail Pharmacy Network (up to 30 days) | CVS Caremark Mail service Pharmacy or CVS Pharmacy (up to 90 days) | CVS Caremark Retail Pharmacy Network (up to 30 days) | CVS Caremark Mail service Pharmacy or CVS Pharmacy (up to 90 days) | CVS Caremark Retail Pharmacy Network (up to 30 days) | CVS Caremark Mail service Pharmacy or CVS Pharmacy (up to 90 days) | CVS Caremark Retail Pharmacy Network (up to 30 days) | CVS Caremark Mail service Pharmacy or CVS Pharmacy (up to 90 days) |
| Preventive (ACA mandated)          | \$0 no deductible                                    | \$0 no deductible  | \$0 no deductible                                    | \$0 no deductible  | \$0 no deductible                                    | \$0 no deductible  | \$0 no deductible                                    | \$0 no deductible  |
| Generic Medicines                  | \$10 co-pay  | \$20 co-pay  | \$10 co-pay  | \$20 co-pay  | \$10 co-pay  | \$20 co-pay  | \$20 co-pay  | \$40 co-pay  |
| Preferred Brand-Name Medicines     | 20%<br>Min \$30<br>Max \$50                          | 20%<br>Min \$60<br>Max \$100                                       | 20%<br>Min \$30<br>Max \$50                          | 20%<br>Min \$60<br>Max \$100                                       | 20%<br>Min \$30<br>Max \$50                          | 20%<br>Min \$60<br>Max \$100                                       | 30%<br>Min \$40<br>Max \$60                          | 30%<br>Min \$80<br>Max \$120                                       |
| Non-Preferred Brand-Name Medicines | 40%<br>Min \$50<br>Max \$70                          | 40%<br>Min \$100<br>Max \$140                                      | 40%<br>Min \$50<br>Max \$70                          | 40%<br>Min \$100<br>Max \$140                                      | 40%<br>Min \$50<br>Max \$70                          | 40%<br>Min \$100<br>Max \$140                                      | 50%<br>Min \$70<br>Max \$90                          | 50%<br>Min \$140<br>Max \$180                                      |
| Specialty Medicines                | 40%<br>Min \$75, Max \$150<br>(30 day supply)        |  | 40%<br>Min \$75, Max \$150<br>(30 day supply)        |  | 40%<br>Min \$75, Max \$150<br>(30 day supply)        |  | 50%<br>Min \$100, Max \$175<br>(30 day supply)       |  |

\* Consumer Driven Health Plans (CDHP) includes Wellness CDHP, CDHP 1 and CDHP 2

If you have any questions about how this change will impact you, please feel free to contact the Benefits Hotline at 317-232-1167 or toll free at 877-248-0007 (if outside of Indianapolis).

## Anthem offers support to help achieve health goals

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

Anthem Health and Wellness Programs provide you with support to help you achieve your health goals. Through Anthem's online tool, you have access to resource materials to learn more about health topics and manage any ongoing health issues such as Diabetes, COPD, Cancer, Pregnancy, Tobacco Use and Weight Management to name a few. To start using the online tools, please go to Anthem.com log in to your account and click the Health & Wellness tab.

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

- **Case Management:** Licensed health care professionals work with you and your treating providers as needed to develop a Care Management plan to help meet your needs. Case Management is designed to help members optimize their health care benefits.
- **ConditionCare:** With the guidance of a dedicated nurse team and health professionals you will gain a better understanding of your health, receive help in following your doctor care plan, and learn how to better manage your health.
- **Future Moms:** Provides moms-to-be with telephone access to nurses to discuss pregnancy-related concerns. This program provides the education and tools to help track the pregnancy week-by-week and prepare for the baby.

For more information about these programs please contact Anthem toll-free at 888-279-5449.

## PeopleSoft login and online self-service instruction guide

You can access your Open Enrollment event 24 hours, seven days per week from Wednesday, **October 25 through Wednesday, November 15 at noon** (EST). Keep in mind, you can access your Open Enrollment event from any computer that allows you access to the internet.

Helpful hints:

1. Your User ID is your first initial of your first name, capitalized, followed by the last six digits of your PeopleSoft number. If you have forgotten your PeopleSoft number, please contact your agency's Human Resources Department or the Benefits Hotline for assistance.
2. If you access the state network, the password used to log on to your computer can be used to log in to 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 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 benefits related questions please call the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007 (if outside of the 317 area code).

**IMPORTANT:** Once you are satisfied with your Open Enrollment elections, it is essential you submit your elections and print a Benefit Election Summary for your records. As a reminder, the 2018 Non-Tobacco Use Agreement can only be accessed through the Open Enrollment event. Please do not attempt to elect to participate in the 2018 agreement by going through PeopleSoft Self-Service and selecting the "Revoke Non-Tobacco Agreement Option", as that platform is only used to revoke your current 2017 Non-Tobacco Use Agreement.

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

- <https://hr.gmis.in.gov/psp/hrprd/?cmd=login&languageCd=ENG&>
- <http://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 log in to PeopleSoft and follow these steps: click on "Self Service," click on "Benefits" and click on "Benefit Summary." Your 2018 benefits are not available to view until January 1, 2018.

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

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

EAP offers a wide variety of free services to you and your dependents and/or household members to help balance work and home life. One of the newest services available is three face-to-face counseling sessions, per issue with a licensed therapist. Access to this benefit is as easy as picking up the phone and calling 800-223-7723.

When you call, select option one, EASY program, from the prompt menu. Once you are connected with an EAP representative, ask them about the three free therapy visits. The representative is trained to assist you in finding a therapist that fits your needs and guide you through the process of scheduling your first appointment. For your convenience, appointments can even be scheduled within LiveHealth Online, face to face conversations with a doctor or therapist using a computer or mobile device. If you are interested in this option, please let the representative know.

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

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

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



Anthem programs

## Anthem's 24 hour NurseLine

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

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

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

To access NurseLine, please call 888-279-5449.

## Your next doctor's visit could be in the privacy of your own home with LiveHealth Online

The State of Indiana is excited to offer online health benefits through LiveHealth Online. Seeing a doctor has never been so convenient. Through LiveHealth Online, you have access to in-network, board-certified doctors 24 hours per day, 7 days per week, 365 days per year. The only thing you need is a computer or mobile device with internet access and a camera.

**LiveHealth**<sup>®</sup>  
O N L I N E

Doctors on LiveHealth Online are available to diagnose and treat a wide variety of medical care needs. Some common items include the flu, a cold, sinus infection, pink eye, rashes and fever. When appropriate, the doctor can even prescribe medicine and send the prescription to the pharmacy of your choice. The average cost of a doctor visit using LiveHealth Online is \$49 or less.



Not only can you be seen by a medical doctor, you can also receive behavioral health services through LiveHealth Online. The behavioral

health services can even be used in coordination with the three free EAP counseling sessions. Below is a quick step-by-step guide on how you can take advantage of the free EAP sessions through LiveHealth Online.

- Call EAP at **800-223-7723** and select option one, EASY Employee Assistance Program.
- Answer some general information, such as your name, date of birth and address.
- Ask the EAP representative about the three free therapy visits.
- The EAP representative provides you with a **Service Key** and **Coupon Code** to be used in LiveHealth Online.
- Go to [www.livehealthonline.com](http://www.livehealthonline.com).
- Sign up or log in to LiveHealth Online.
  - To sign up: Download the mobile app from Google Play or the App Store. It is free and takes less than two minutes to download. Or visit [www.livehealthonline.com](http://www.livehealthonline.com) and click the "Sign Up" button at the top right corner of the home page and create an account. All you need to provide is an email address (this becomes your user name), create a password, enter your first and last name, sex, state and agree to the terms of use. You are now registered and ready to connect to a provider.
  - OR, Log in by clicking the "Log In" button using your username (email address) and password.
- Select **Add a Service Key** in the **MY Services** section and enter the provided Service Key.
- Select **Work-Life Solutions EAP**, and choose the appointment tab. You can schedule an appointment by date or therapist. After scheduling the appointment, you receive a confirmation email.
- Fifteen minutes before your appointment you receive a reminder email. To initiate the appointment, you need to click on the "Start Visit" button, included in the email.
- Enter the Coupon Code in the payment screen for each of the three free visits. This reduces the member cost share to \$0.
- You are then connected to the therapist.

Sign up for LiveHealth Online today by visiting [www.livehealthonline.com](http://www.livehealthonline.com) or downloading the mobile app from your app store.

## The Non-Tobacco Use Incentive is offered again in 2018

The Non-Tobacco Use Incentive is offered again for the 2018 plan year. Receive a \$35 reduction in your group health insurance bi-weekly premium by accepting the agreement during Open Enrollment. By accepting the incentive, you agree to not use any form of tobacco products in 2018. This applies to employees who have never used tobacco products, who have refrained from using tobacco products in past years and to those who have decided to quit using tobacco products prior to January 1, 2018. Keep in mind, by accepting the agreement you agree to be subject to testing for nicotine at any time during the year. The Non-Tobacco Use Agreement must be completed each year online.

The Non-Tobacco Use Incentive is only available to employees who have enrolled in medical coverage. You do not have access to the agreement if you waive medical coverage for plan year 2018. The reduction in your group health insurance bi-weekly premium only applies to your employee medical

premium, and does not apply to dental, vision or life insurance premiums.

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

Cessation aids like nicotine gum, lozenges or patches do not contain tobacco leaves. Therefore, the use of nicotine cessation aids or other non-tobacco products would not violate the Non-



Tobacco Use Agreement. However, if you use cessation aids, please keep all of your receipts for these products to demonstrate your compliance with the Agreement.

The Non-Tobacco Use Incentive does not carry over from year to year. If you want to participate in 2018, you must access your Open Enrollment event within PeopleSoft and accept the agreement.

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

### Vision

## No changes to Vision benefits in 2018

Vision and health conditions, such as diabetes and high blood pressure, can be revealed and detected early through a comprehensive eye exam. An annual exam with dilation will only cost you \$10 at an in-network provider. Take care of your vision and overall health by taking the initiative to have an exam completed this year.

In addition to the exam, you can save money on contacts and frames if needed. The plan allows for frames every 24 months and lenses, including contact lenses, every 12 months. For frames, the plan has a \$110 allowance with a \$25 standard lenses copayment when using an in-network provider. To view your current eligibility for an exam, frames, lens or contact, please follow the below steps.

- Go to [www.Anthem.com](http://www.Anthem.com) and log in to your account
- Click on the "Benefits" tab on the top of the page
- Click on the "Vision" tab on the top of the page
- Select the coverage Period you wish to view
- Click on the "Vision Benefit Details"

button on the bottom of the page

- On the Blue View Vision, site click the "View Your Benefits" tab at the top of the page
- Select Member
- Select Group "Blue View Select SOI NASCO (1004118)"
- Click the "Display Benefits" button on the bottom of the page
- Under the "Service Eligibility" section, you will find you current eligibility for an exam, frames, lens and contacts

Through Anthem Blue View Vision, you and your dependents have a large network of ophthalmologists, optometrists, opticians and retail locations to choose from. To find an in-network provider go to [www.Anthem.com](http://www.Anthem.com) and log in to your account. Once there, click on the "Find / Rate a Doctor" tab on the top of the page and then complete the search criteria. Please make sure you select "Vision Professional" on the first drop down menu.

More information about vision coverage can be found at: [www.in.gov/spd/openrollment](http://www.in.gov/spd/openrollment).

### Dental

## No changes to the state's Dental plan during 2018

Good dental health may be more important than you think. Studies identify a link between oral health and chronic conditions such as heart disease. Lower your risk by keeping up with your preventive exams. Under the Anthem Dental Complete plan, your diagnostic and preventive services such as teeth cleanings, periodic oral exam and bitewing X-rays are covered at 100 percent when using an in-network provider. Other in-network services such as fillings, crowns and root canals are covered at 80 percent.

Similar to the other medical plans, you can realize the greatest savings by going to an in-network dentist.

While network dentists sign a contract with Anthem to limit fees, nonparticipating dentists do not have limits on the amount they can charge you for services. If you

(Continued on next page)



## Coverage

# Make sure your dependents are eligible

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

"Dependent" means:

- A. 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 percent of his or her financial support from the parent

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

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

**Please Note:** If you have questions or concerns about dependent coverage, or wish to enroll a dependent on your plans during Open Enrollment who is over age 26 and meets the definition of a disabled dependent but was not certified last year, call the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007 (if outside of the 317 area code), to initiate the disabled dependent certification process with Anthem. To be eligible to enroll your dependent(s) as part of your Open Enrollment event for an effective date of January 1, 2018, you must contact the Benefits Hotline during Open Enrollment and Anthem must certify that your dependent(s) meets the definition of a disabled dependent.



*The Tapp family participates in the Run The State 5K at Fort Harrison State Park in August of 2017.*

(Continued from page 8)

## No changes to the state's Dental plan

decide to go to a nonparticipating dentist, be sure you understand your potential out-of-pocket costs before you receive services.

A list of dentists within the Dental Complete network can be found by going to [www.Anthem.com](http://www.Anthem.com) and logging in to your account. Once there, click on the "Find / Rate a Doctor" tab on the top of the page and then complete the search criteria. Please make sure you select "Dental Professional" on the first drop down menu.

More information about dental coverage can be found at: [www.in.gov/spd/openenrollment](http://www.in.gov/spd/openenrollment).

## Coverage

# Dual coverage is not allowed

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

A second example occurs when an employee who has retired from one area of state employment begins active work in another state position. In this instance, you have the choice to continue your retiree coverage and waive your active employee coverage, or vice versa. However, you are not permitted to carry state retiree insurance and active state employee coverage simultaneously. **Dual coverage is only permitted for dependent life.**

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

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

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

### Disabled Dependents

Disabled dependents can be enrolled in any of your desired plans during the Open Enrollment period if they have not exceeded the month in which they turn 26 or were approved through the Anthem recertification process last year. If you wish to enroll a dependent

during Open Enrollment who is over the age of 26 and meets the definition of a disabled dependent, but was not certified last year, please call the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007 (if outside of the 317 area code).

Upon your request, Anthem is notified to mail you an Application for Continuation of Coverage. This form must be completed and returned to Anthem within 30 days of the issue date. If Anthem certifies your dependent meets the definition of a disabled dependent, the state then enrolls your dependent in your plans with the effective date of January 1, 2018.

**Please note: you must initiate the certification process by contacting the Benefits Hotline during Open Enrollment to be eligible to enroll your dependent(s) as part of your Open Enrollment event for an effective date of January 1, 2018.**

Outside of Open Enrollment, you may

only add a disabled dependent through a qualifying event or when your dependent turns age 26. Similar to the process outlined above, you must contact the Benefits Hotline to initiate the certification process. Notification must be done within 30 days of the qualifying event or within 31 days from your dependent turning 26-years-old.

**Please note:** In order for a disabled dependent to continue coverage past the month in which they turn 26 years of age, that dependent child must have been deemed disabled prior to age 19. If a dependent child was deemed disabled after age 19, they are not eligible to continue coverage past the month they turn age 26.

**OE 2018**

Benefits Open Enrollment

OCT. 25 - NOV. 15

Deadline is Wednesday,  
Nov. 15 by noon EST

### Making Changes

## Qualifying events allow for changes throughout the year

After noon (EST) on Wednesday, November 15, you are not able to make further changes to your benefits. This means you must be certain you elect the coverage that is right for you and add all eligible dependents you wish to cover to all plans (health, vision and dental). After Open Enrollment, you can only make changes in conjunction with a qualifying event.

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

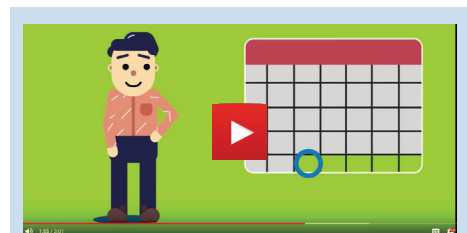
- Changes in your legal marital status (marriage, divorce, separation, annulment or death of spouse).
- Changes in the number of

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 are not able to add dependents until the next Open

Enrollment period. Please note that an ex-spouse is ineligible for coverage as of the day of divorce. It is important that you report ineligible dependents even if it is beyond the 30 day period to minimize recovery of claims.



Visit the [State of Indiana Employee's YouTube channel](#) to watch a video explanation about qualifying events.

Dependents' name

## Are dependents' names and social security numbers entered and correct in Peoplesoft?

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

In order to file the health coverage information with the IRS, each employee and dependent's name and social security number must match the information listed on their social security card. Please take a moment to review your dependent information by following the below steps:

- Log in to PeopleSoft HR
- Click Main Menu
- Click Self Service
- Click Benefits
- Click Dependent/Beneficiary Info
- Click on each dependent name and review information
- If a dependent is missing their social security number, please click the edit button, add the information and then click save.
- If one of your dependent's names

have changed or you notice an error on their social security number, please provide a copy of their social security card to State Personnel Benefits via one of the methods below:

- Mail: State Personnel Department  
Attn: Benefits Division  
402 W. Washington St. Room W161  
Indianapolis, IN 46204
- Fax: 317-232-3011

It is your responsibility to ensure that the correct information is in PeopleSoft for you and all of your dependents. If it is identified that PeopleSoft has an incorrect name or social security number on file, you will be required to provide documentation to State Personnel Benefits to correct your record.

Please note: if you do not provide your dependent's social security number, the IRS may be unable to match the information you provide on your tax return. This may result in receiving an inquiry from the IRS or being liable for a shared responsibility payment. For more information please visit our FAQ page or contact Indiana State Personnel Benefits at 317-232-1167 toll-free at 877-248-0007 (if outside of the 317 area code).

## Newborns' and Mothers' Health Protection Act of 1996

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

ID cards

## New membership ID cards

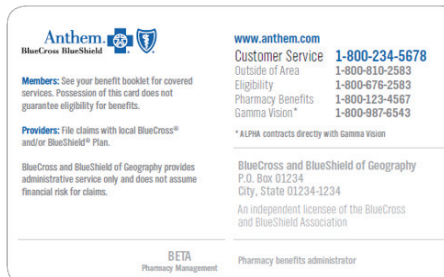
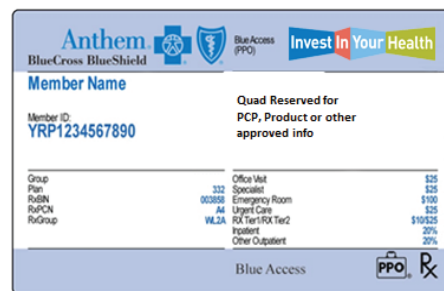
All State of Indiana health plan participants will be receiving a new ID card in the mail for the 2018 plan year. Each family member will receive his or her own unique card prior to Jan. 1 with his or her name. As in the past, the cards will be used for medical, prescription, dental and vision.

Some of the key changes to the card include:

- Updated prescription vendor information to CVS Caremark
- Replaced Identification Number to Member ID, highlighted in blue for emphasis
- Cost share information is highlighted in blue for greater readability
- Primary customer service number is highlighted for improved readability

Please continue to use your current card for any health or prescription services received before January 1, 2018. Beginning Jan. 1, present your new ID card to your provider or pharmacy. If you use your old ID card, your claim may be denied.

Below is a sample of the new card\*.



\*Sample only. Data on card will vary depending upon group and benefits.

# A non-emergent Emergency Room visit may be denied

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

Effective January 1, 2018, non-emergency services will no longer be covered when treated in an emergency room (ER), if more appropriate settings are available. ER claims will be reviewed by Anthem using the prudent layperson standard and potentially denied. If your claim is denied, you will be solely responsible for the ER charges. Please note, that non-emergency visits to the ER will be covered if:

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

When seeking medical care, it is important that you consider all your options. Below is a brief overview of each alternative.

| Care Facility        | Cost    |
|----------------------|---------|
| LiveHealth Online    | \$49    |
| Urgent Care Center   | \$190   |
| Doctor’s Office      | \$125   |
| Retail Health Clinic | \$85    |
| Emergency Room       | \$1,200 |

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

*As a reminder, Anthem’s NurseLine is available 24/7 for those times you are not sure where you should seek medical care. If you are advised by the NurseLine to seek treatment at the ER and it is later determined that the visit was for a non-emergent visit, Anthem will approve the visit. To access NurseLine, please call 888-279-5449.*

|            | LiveHealth Online  | Retail Health Clinic   | Doctor’s Office   | Urgent Care  | Emergency Room  |
|------------|--|--|---|--|---|
| Overview   | See a doctor or therapist without leaving your home!   | Visit your local retail clinic for help with mild rashes, fevers, or colds.  | Your doctor’s office is a great place for scheduled care and check-ups, and you should try them first during office hours in a non-life-threatening emergency.  | Urgent Care is accessible in many communities at all hours of the day and night. Doctors and nurses can help with non-life-threatening but urgently-needed care quickly.   | You should always go to the ER if you believe your life or health is in danger. |
| Conditions | Flu, Allergies, Fever, Sinus Infections, Diarrhea, Pinkeye and other eye infections, Skin infections or rash | Rash, Minor burns, Cough, Sore Throat, Shots, Ear or sinus pain, Burning with urination, Minor fever, Cold, Minor allergic reactions, Bumps, Cuts, Scrapes, Eye pain or irritation | Mild asthma, Rash, Minor burns, Minor fever or cold, Nausea or diarrhea, Back pain, Minor headache, Ear or sinus pain, Cough, Sore throat, Bumps, Cuts, Scrapes, Minor allergic reactions, Burning with urination | Sprains & strains, Nausea or diarrhea, Ear or sinus pain, Minor allergic reactions, Animal bites, Back pain, Cough, Sore throat, Mild asthma, Burning with urination, Rash, Minor burns, x-rays, Stiches, Minor fever or cold, Eye pain or irritation, Minor headache, Shots, Bumps, Cuts, Scrapes |   |

## State continues to contribute to Health Savings Account (HSA)

The state continues to contribute 39 percent or more of the Consumer-Driven Health Plan (CDHP) annual deductible to your Health Savings Account (HSA) in 2018, depending on what plan you choose. The initial contribution will be made on your January 10, 2018 paycheck. Employees enrolled in a CDHP effective from January 1, 2018 through June 1, 2018 receive the full pre-fund amount. CDHPs effective after June 2, 2018, but before December 2, 2018, receive one-half of the initial contribution. The initial pre-fund contribution is based on the coverage type (single/family) that is effective January 1, 2018 or your first day of coverage in a state health plan during 2018.

If you have an active HSA with The HSA Authority at Old National Bank and wish to continue receiving the state's contributions in 2018, you do not need to open a new HSA account. Employee HSA contribution amounts do not carry over from year to year, if you would like to contribute to your account during 2018, you need to access your PeopleSoft record and enter your desired contribution.

If you are electing to participate in an HSA for the first time in 2018, you must edit the online HSA option in PeopleSoft and choose the HSA that corresponds to your medical CDHP election in order to receive the state's

contribution. In addition to electing the HSA option, you need to open an HSA account with The HSA Authority before January 1, 2018.

directly to [www.theHSAauthority.com](http://www.theHSAauthority.com) and click on the "Enroll Now" button. The first page of this online session says: If you have been instructed by

| Plan                | 2018 Initial Contribution | 2018 Bi-Weekly Contribution | Annual Employer Contribution |
|---------------------|---------------------------|-----------------------------|------------------------------|
| Wellness HSA Single | \$625.56                  | \$24.06                     | \$1,251.12                   |
| Wellness HSA Family | \$1,251.12                | \$48.12                     | \$2,502.24                   |
| HSA 1 Single        | \$500.76                  | \$19.26                     | \$1,001.52                   |
| HSA 1 Family        | \$1,001.52                | \$38.52                     | \$2,003.04                   |
| HSA 2 Single        | \$299.52                  | \$11.52                     | \$599.04                     |
| HSA 2 Family        | \$599.04                  | \$23.04                     | \$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 preventive 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

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" to begin the state application.

You need the following information to complete the HSA application online:

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

## HSAs have a maximum contribution limit

Contributions are allowed up to the maximum statutory limit. The maximum annual contribution for 2018 is \$3,450 for self-only policies and \$6,900 for family policies. Individuals age 55 and over may make an additional catch up contribution of up to \$1,000 in 2018.

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

| Plan         | Coverage | IRS Maximums | State Contribution | Max EE Contribution | Max-Bi Weekly | Max EE Contribution Over 55 | Max Bi-Weekly Over 55 |
|--------------|----------|--------------|--------------------|---------------------|---------------|-----------------------------|-----------------------|
| Wellness HSA | Single   | \$3,450      | \$1,251.12         | \$2,198.88          | \$84.57       | \$3,198.88                  | \$123.03              |
| Wellness HSA | Family   | \$6,900      | \$2,502.24         | \$4,397.76          | \$169.14      | \$5,397.76                  | \$207.60              |
| HSA 1        | Single   | \$3,450      | \$1,001.52         | \$2,448.48          | \$94.17       | \$3,448.48                  | \$132.63              |
| HSA 1        | Family   | \$6,900      | \$2,003.04         | \$4,896.96          | \$188.34      | \$5,896.96                  | \$226.80              |
| HSA 2        | Single   | \$3,450      | \$599.04           | \$2,850.96          | \$109.65      | \$3,850.96                  | \$148.11              |
| HSA 2        | Family   | \$6,900      | \$1,198.08         | \$5,701.92          | \$219.30      | \$6,701.92                  | \$257.76              |

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

The IRS established Health Savings Accounts (HSAs) as a method to provide individuals a tax advantage to offset their health care costs. In doing so, the IRS created eligibility criteria to qualify for the account. Enrolling in Medicare, Medicaid or HIP 2.0 disqualifies you from having contributions into an HSA. Once enrolled in any of these plans, you may not receive or make any contributions into an HSA.

Although you can no longer make contributions to your HSA once you are covered by Medicare, Medicaid or HIP 2.0, the money accumulated in your HSA from past years remains yours to spend, tax-free, on eligible expenses, including Medicare copays or deductibles, vision expenses and dental expenses. If you are age 65 or over, you also have the option to withdraw the money for any purpose and pay only the income tax without penalty. The same rules also apply if you receive Social Security disability benefits and are enrolled in Medicare.

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

### Medicare

If you elect to receive Social Security benefits, you are automatically enrolled in Medicare Part A when you turn age 65. If you wish to participate in a Health Savings Account (HSA), you should decline to receive Social Security retirement benefits and waive Medicare

Part A. Keep in mind there are potential consequences if you choose to decline or postpone your enrollment. Additionally, if you decided not to take Medicare when you first qualify, please be advised that your Medicare Part A start date may backdate up to six months when you apply for Social Security benefits. Please carefully research all of your options before making your decision.

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

### Medicaid and HIP 2.0

According to IRS regulations, an individual who is enrolled in Medicaid or HIP 2.0 is not eligible to make or receive contributions to an HSA. There are tax consequences to both the individual and the employer, if the employer is also contributing to an HSA for the employee. Similar to Medicare, if your dependent(s) is/are covered by Medicaid or HIP 2.0 but you are not, you may continue to receive contributions to your HSA. Eligibility is based on the subscriber/ account holder.

## State plans provide creditable coverage

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

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

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

**OE** 2018

Benefits Open Enrollment

**DEADLINE IS  
WEDNESDAY, NOV. 15**

**by noon EST**

## Flexible Spending Account (FSA)

# FSA's give tax-free help for qualified medical expenses with no administration fee

A Flexible Spending Account (FSA) provides another opportunity for you to better control your health care dollars. By tucking away pre-tax dollars from your paycheck, you have an account that is dedicated to the reimbursement of qualified medical, vision and dental expenses. In addition, the bi-weekly employee administration fee is paid by the state during the 2018 plan year, providing you with even more opportunities to save.

There are three types of FSAs: Medical Care, Limited Purpose Medical Care and Dependent Care. All of the state's FSA programs are administered through Key Benefit Administrators and have a use-it-or-lose-it rule. Money left at the end of the plan year is not rolled over or reimbursed, so plan carefully. You must re-enroll in medical and dependent care FSAs each year if you wish to continue to participate. If you continue participation, do not discard the debit card from Key Benefit Administrators. New cards are not automatically issued each year.

### Medical Care & Limited Purpose FSA

Medical Care and Limited Purpose FSAs allow employees to use pre-tax dollars to cover health care costs for medical, dental, vision, hearing and other out-of-pocket expenses not paid by insurance. For 2018, 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 Consumer Driven Health Plan (CDHP) is met (\$1,350 for single and \$2,700 for family, per federal regulations). Once the minimum deductible is met, the Limited Purpose FSA can be used as a Medical Care



FSA. If you are enrolled in a CDHP with a Health Savings Account (HSA), your FSA automatically becomes a Limited Purpose FSA. You do not need to meet the minimum deductible to use the funds in your Limited Purpose FSA for dental and vision expenses. You can pay for dental and vision expenses from your Limited Purpose FSA at any point during the year.

### Dependent Care FSA

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

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

- [View more information and download enrollment information packets.](#)

## Flu Shot

# Get your flu shot

The number one way to protect yourself and your family from the flu this year is to get a flu vaccination. According to a research study by the Centers for Disease Control and Prevention (CDC), the flu vaccine reduces the risk of seeing a doctor in conjunction with the flu by approximately 60 percent. While the vaccine does not guarantee you won't catch the flu, it does reduce the chances, and, if you do get sick, your illness typically is milder.

It is not too late for you to get a flu vaccination. CVS has partnered with the state to offer flu shot clinics at many state facilities across Indiana. The onsite vaccination clinics will be available to anyone 11 years of age and older. For employees and dependents who carry state insurance, the flu vaccine is covered at 100 percent. Please be sure to bring your Anthem ID and waiver form when attending the flu shot clinic.

If you do not carry state insurance, you may still receive a flu shot at one of the clinics. The cost of the vaccine will vary depending on your age. For those patients under 65 years of age the cost will be \$40.99, while patients over the age of 65 can receive their vaccine for \$66.99. Payments can be made by check to CVS Pharmacy. Please note, other insurances may also be accepted but are not guaranteed.

**Find the schedule of state-sponsored Flu Shot Clinics at [www.investinyourhealthindiana.com/flu-shots/](http://www.investinyourhealthindiana.com/flu-shots/)**

*Note: Nasal vaccines are not being provided this year.*

## New life insurance option - Voluntary AD&D

Indiana State Personnel is excited to announce a new life insurance offering for the 2018 plan year. During Open Enrollment you will have the option to select voluntary accidental death and dismemberment (AD&D) coverage. This benefit provides a payment in the event you experience a fatal accident or non-fatal accident involving dismemberment or loss of eyesight, hearing or other key function such as loss of hands, feet, or fingers.

Voluntary AD&D is guaranteed issue meaning that you are not required to apply for the coverage through Evidence of Insurability (EOI). Enrollment in basic life and AD&D is the only requirement to enroll. When enrolling in voluntary AD&D you may elect any amount of coverage from \$10,000 to \$500,000, in \$10,000 increments. The bi-weekly rate for coverage is \$0.009 per \$1,000 of coverage.

Please note, that at age 65 there is an age reduction in benefits. The amount of coverage on an employee age 65 or older will be a percentage of the amount in force on their birthdate in accordance with the following table:

| Age of Employee | Amount of Insurance |
|-----------------|---------------------|
| 65 -69          | 65%                 |
| 70-74           | 50%                 |
| 75 and older    | 25%                 |

Age reductions will apply the first day of the month following an insured employee's applicable birthday.

For more information on what is covered under the Voluntary AD&D, please see the policy located at <http://www.in.gov/spd/3150.htm>.

## Review and update your life insurance beneficiary information

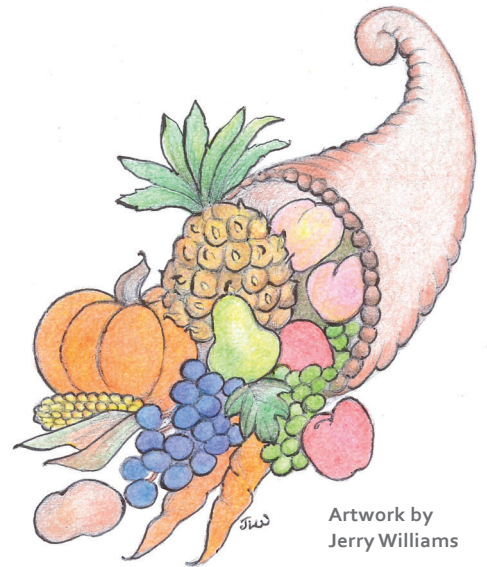
Open Enrollment is a great time to review your current life insurance beneficiary information. It only takes a couple of minutes to verify your beneficiary designations and update their contact information in your Open Enrollment event. By routinely checking this information, you are assuring you have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

In addition to confirming your beneficiary allocation, you should also update their contact information. It is extremely important PeopleSoft has the correct address and phone number for all of your beneficiaries. This information is used to identify and locate your

designated beneficiaries if a claim is processed. Without updated contact information, it may take a significantly longer period of time to pay out a claim.

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.

Note: All beneficiary changes made within your Open Enrollment event take effect on January 14, 2018, unless you are employed with a direct bill agency, in which case your changes will be effective January 1, 2018.



### Federal Notice

## HIPAA Notice of Special Enrollment Rights

If you decline 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 within 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 to obtain more information, please call the Benefits Hotline at 317-232-1167 or toll-free at 877-248-0007 (if outside of the 317 area code).



## Life Insurance - are you properly prepared?

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

Some life insurance changes can be completed within your Open Enrollment event. These changes include decreasing your coverage level or dropping any of your life insurance plans. You may also elect voluntary AD&D and child dependent life insurance, as long as you are currently enrolled in basic life and AD&D. Additionally, you may update your beneficiary information and/or allocation amounts. All changes are effective in January 2018.

Outside of Open Enrollment you may request to pick up or make changes to your life insurance plans by completing the Evidence of Insurability (EOI) process at any time throughout the year. Allowable changes include increasing your coverage level and/or adding an eligible spouse to your dependent life insurance plan. This process applies to the basic life and AD&D, supplemental and dependent life policies.

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

Please keep in mind, you may also make changes to your beneficiary information at any point during the year by accessing PeopleSoft self-service. Instructions on how to change your life insurance beneficiaries can be found at <http://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 December 31, 2017, are limited to \$200,000 of supplemental life insurance coverage. Employees reaching age 65 during the plan year are automatically reduced to \$200,000 of supplemental life insurance coverage and their payroll deductions are adjusted accordingly.

### Annual Physical

## Don't forget to get your annual physical

As we near the end of the year, it is important to remember to set some time aside to get your annual physical, if you have not already done so. It is easy to get in the mindset that you don't need a physical if you don't feel sick. However, having an annual physical is one of the best ways to maintain your health.

Preventive care, such as an annual physical, can help identify underlying health concerns before they become a major issue. By routinely visiting your doctor, you can establish a baseline on your health statistics regarding your weight, height, blood sugar, blood pressure and cholesterol. In addition, you are able to keep your doctor informed about your family's changing medical history. By doing so, your doctor will be able to identify any significant changes in your health statistics or concerns based on your family history that could indicate a problem. Once identified, an early treatment plan can be established to prevent the condition from getting worse.

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

(Continued on page 18)

## Women's Health and Cancer Rights Act of 1998

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

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

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

(Continued from page 17)

### Don't forget to get your annual physical

doctor near you, please follow the below steps.

- Log in to [www.Anthem.com](http://www.Anthem.com)
- Click the "Find / Rate a Doctor" tab on the top of the page
- Complete the search criteria
  - Select "Doctor / Medical Professional" on first drop down menu
  - Select "Family / General Practice, Internal Med" on the second drop down menu
- Click the "Search" tab

## Complete statewide required trainings before Nov. 2

At the beginning of October, Indiana State Personnel (INSPD), in partnership with the Inspector General's Office and IOT, launched two mandated trainings: Indiana Resource Use Agreement (IRUA); and Ethics. Preventing Workplace & Sexual Harassment training will also be launched for the agencies who have not completed it for 2017. Contractors are excluded from taking Preventing Sexual Harassment and Ethics training.

We are half-way through the completion deadline. Employees must complete the trainings by November 2. Our goal is to have the state attain 100 percent compliance. Please reach out to your agency's human resources department or [INSPD Training](#) if you have any questions.



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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS**

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

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

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

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

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

To request special enrollment or obtain more information, contact Anthem toll free at 1-877-814-9709.



# YOUR RIGHTS UNDER USERRA THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

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

## REEMPLOYMENT RIGHTS

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

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

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

## RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

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

then an employer may not deny you:

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

because of this status.

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

## HEALTH INSURANCE PROTECTION

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

## ENFORCEMENT

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

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



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



**U.S. Department of Justice**



**Office of Special Counsel**



**1-800-336-4590**

Publication Date — April 2017

## 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](http://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](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://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 August 10, 2017. Contact your State for more information on eligibility –**

|   |   |
|---|---|
| <b>ALABAMA – Medicaid</b>   | <b>FLORIDA – Medicaid</b>   |
| Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a><br>Phone: 1-855-692-5447   | Website: <a href="http://flmedicaidtplrecovery.com/hipp/">http://flmedicaidtplrecovery.com/hipp/</a><br>Phone: 1-877-357-3268   |
| <b>ALASKA – Medicaid</b>  | <b>GEORGIA – Medicaid</b>   |
| The AK Health Insurance Premium Payment Program<br>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a><br>Phone: 1-866-251-4861<br>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a><br>Medicaid Eligibility:<br><a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a> | Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a><br>- Click on Health Insurance Premium Payment (HIPP)<br>Phone: 404-656-4507   |
| <b>ARKANSAS – Medicaid</b>  | <b>INDIANA – Medicaid</b>   |
| Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a><br>Phone: 1-855-MyARHIPP (855-692-7447)  | Healthy Indiana Plan for low-income adults 19-64<br>Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a><br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a><br>Phone 1-800-403-0864 |
| <b>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</b>   | <b>IOWA – Medicaid</b>  |
| Health First Colorado Website:<br><a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a><br>Health First Colorado Member Contact Center:<br>1-800-221-3943/ State Relay 711<br>CHP+: <a href="http://Colorado.gov/HCPF/Child-Health-Plan-Plus">Colorado.gov/HCPF/Child-Health-Plan-Plus</a><br>CHP+ Customer Service: 1-800-359-1991/<br>State Relay 711     | Website:<br><a href="http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a><br>Phone: 1-888-346-9562  |



|  |   |
|--|---|
| <p align="center"><b>KANSAS – Medicaid</b></p> <p>Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a><br/> Phone: 1-785-296-3512</p>  | <p align="center"><b>NEW HAMPSHIRE – Medicaid</b></p> <p>Website:<br/> <a href="http://www.dhhs.nh.gov/oii/documents/hippapp.pdf">http://www.dhhs.nh.gov/oii/documents/hippapp.pdf</a><br/> Phone: 603-271-5218</p>   |
| <p align="center"><b>KENTUCKY – Medicaid</b></p> <p>Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a><br/> Phone: 1-800-635-2570</p>  | <p align="center"><b>NEW JERSEY – Medicaid and CHIP</b></p> <p>Medicaid Website:<br/> <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a><br/> Medicaid Phone: 609-631-2392<br/> CHIP Website:<br/> <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a><br/> CHIP Phone: 1-800-701-0710</p> |
| <p align="center"><b>LOUISIANA – Medicaid</b></p> <p>Website:<br/> <a href="http://dbh.louisiana.gov/index.cfm/subhome/1/n/331">http://dbh.louisiana.gov/index.cfm/subhome/1/n/331</a><br/> Phone: 1-888-695-2447</p>  | <p align="center"><b>NEW YORK – Medicaid</b></p> <p>Website:<br/> <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a><br/> Phone: 1-800-541-2831</p>  |
| <p align="center"><b>MAINE – Medicaid</b></p> <p>Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a><br/> Phone: 1-800-442-6003<br/> TTY: Maine relay 711</p>   | <p align="center"><b>NORTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://dma.ncdhhs.gov/">https://dma.ncdhhs.gov/</a><br/> Phone: 919-855-4100</p>   |
| <p align="center"><b>MASSACHUSETTS – Medicaid and CHIP</b></p> <p>Website:<br/> <a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a><br/> Phone: 1-800-862-4840</p>   | <p align="center"><b>NORTH DAKOTA – Medicaid</b></p> <p>Website:<br/> <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a><br/> Phone: 1-844-854-4825</p>  |
| <p align="center"><b>MINNESOTA – Medicaid</b></p> <p>Website: <a href="http://mn.gov/dhs/people-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp">http://mn.gov/dhs/people-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp</a><br/> Phone: 1-800-657-3739</p> | <p align="center"><b>OKLAHOMA – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a><br/> Phone: 1-888-365-3742</p>  |
| <p align="center"><b>MISSOURI – Medicaid</b></p> <p>Website:<br/> <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a><br/> Phone: 573-751-2005</p>   | <p align="center"><b>OREGON – Medicaid</b></p> <p>Website:<br/> <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a><br/> <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a><br/> Phone: 1-800-699-9075</p>   |
| <p align="center"><b>MONTANA – Medicaid</b></p> <p>Website:<br/> <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a><br/> Phone: 1-800-694-3084</p>  | <p align="center"><b>PENNSYLVANIA – Medicaid</b></p> <p>Website:<br/> <a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm</a><br/> Phone: 1-800-692-7462</p>  |
| <p align="center"><b>NEBRASKA – Medicaid</b></p> <p>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a><br/> Phone: (855) 632-7633<br/> Lincoln: (402) 473-7000<br/> Omaha: (402) 595-1178</p>  | <p align="center"><b>RHODE ISLAND – Medicaid</b></p> <p>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a><br/> Phone: 855-697-4347</p>   |
| <p align="center"><b>NEVADA – Medicaid</b></p> <p>Medicaid Website: <a href="https://dwss.nv.gov/">https://dwss.nv.gov/</a><br/> Medicaid Phone: 1-800-992-0900</p>  | <p align="center"><b>SOUTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a><br/> Phone: 1-888-549-0820</p>   |

|  |  |
|--|--|
| <b>SOUTH DAKOTA - Medicaid</b>   | <b>WASHINGTON – Medicaid</b>   |
| Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a><br>Phone: 1-888-828-0059  | Website: <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a><br>Phone: 1-800-562-3022 ext. 15473 |
| <b>TEXAS – Medicaid</b>  | <b>WEST VIRGINIA – Medicaid</b>  |
| Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a><br>Phone: 1-800-440-0493  | Website: <a href="http://mywvhipp.com/">http://mywvhipp.com/</a><br>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)   |
| <b>UTAH – Medicaid and CHIP</b>  | <b>WISCONSIN – Medicaid and CHIP</b>   |
| Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a><br>CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a><br>Phone: 1-877-543-7669  | Website: <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a><br>Phone: 1-800-362-3002  |
| <b>VERMONT– Medicaid</b>   | <b>WYOMING – Medicaid</b>  |
| Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a><br>Phone: 1-800-250-8427  | Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a><br>Phone: 307-777-7531  |
| <b>VIRGINIA – Medicaid and CHIP</b>  |  |
| Medicaid Website:<br><a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a><br>Medicaid Phone: 1-800-432-5924<br>CHIP Website:<br><a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a><br>CHIP Phone: 1-855-242-8282 |  |

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

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

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

### Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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

## NOTICE REGARDING WELLNESS PROGRAM

Indiana's Humana Go365 wellness program & non-tobacco use incentives are voluntary and available to all individuals enrolled in the State health insurance plans. The programs are administered according to federal rules permitting employer-sponsored wellness programs that seek to improve participants health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in Humana Go365 you will be encouraged to complete:

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

You are not required to complete the HRA or to participate in the blood test or other medical examinations. However, employees who choose to participate in Humana Go365 may receive incentives of:

- Wellness "Bucks" (up to an approximate cash value of \$300 for participation in certain health-related activities such as: tracking workouts, health education courses, goal setting and health coaching).
- Eligibility for the Wellness CDHP financial incentives (i.e., lower premiums and higher Health Savings Account contributions, for reaching an Earned Status of Silver or higher by the annual deadline).

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you Humana G0365 services, such as goal setting, educational activities, fitness recommendations, or health coaching. You also are encouraged to share your results or concerns with your own doctor.

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

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

## **Protections from Disclosure of Medical Information**

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the State of Indiana may use aggregate information it collects to design a program based on identified health risks in the workplace, Humana Go365 will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with Humana Go365 will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in Humana Go365. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are registered/licensed health care providers (in order to provide you with services), or as necessary for plan administration.

In addition, all medical information obtained through Humana Go365 will be maintained separate from your personnel records, information stored electronically will be protected, and no information you provide as part of Humana Go365 will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

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

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