

Notices

Eligibility Requirement to Enroll

There are no pre-existing condition limitations for any of the state's plans. All active, full-time employees and elected or appointed officials are eligible to participate. For the purpose of benefits eligibility, full-time employees are defined as active employees whose regular work schedule is at least 37½ hours per week. Part-time, intermittent and hourly (temporary) employees are not eligible for insurance or related benefits.

Dependents of eligible employees may be covered under the state's benefit plans. Dependents are defined as:

Spouse: One's wife or husband. An ex-spouse is not eligible for coverage, even if court ordered.

Children: Natural-, step-, foster or legally adopted children; children who reside in the employee's home for whom the employee or spouse has been appointed legal guardian or awarded legal custody by a court, under the age of 26.

Age limitation: Dependent children are eligible for coverage until their 26th birthday.

If the dependent child is both incapable of self-sustaining employment by reason of mental or physical disability and is chiefly dependent upon the employee for support and maintenance prior to age 19, the dependent child's coverage shall continue if satisfactory evidence of such disability and dependency is received within 120 days after child's 26th birthday. Coverage for the dependent will continue until the employee discontinues his coverage or the disability no longer exists.

A dependent child of the employee who attained age 26 while covered under another health care policy and met the disability criteria specified above, is an eligible dependent for enrollment so long as no break in coverage longer than 63 days has occurred immediately prior to enrollment. Proof of disability prior to age 19 and proof of prior coverage will be required. The plan requires annual documentation from a physician after the child's attainment of the limiting age.

Adult relatives: Even in situations where the employee possesses a court order or legal guardianship, adult relatives (e.g. father, mother, aunt, uncle, niece, nephew) do not qualify as dependents and are not eligible for benefits through the state of Indiana except as dependents under the Dependent Care Spending Account.

Qualifying Events

Making changes after open enrollment

After noon (Indianapolis time) on Wednesday, Nov. 20, you will not be able to make changes to your benefits. This means you must be certain you have made all the best choices and remembered to add all eligible dependents to all plans. After Open Enrollment, you can only make changes due to a qualifying event. Qualifying events are governed by the IRS. Examples of qualifying events are:

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

Failure to report the qualifying event and complete any necessary paperwork within 30 calendar days means you will not be able to add dependents until the next enrollment period.



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Dual Coverage

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

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

Dual coverage is only permitted for dependent life.

Dependent Eligibility

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

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

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

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

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

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

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Creditable Coverage Disclosure Notice

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

Second, the state of Indiana's Third Party Administrator determined that the prescription drug coverage offered by Express Scripts is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

The Children's Health Insurance Program Reauthorization Act of 2009 is a premium assistance program for employees who are eligible for health coverage from their employer, but are unable to afford the premiums. States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office. You can also call 1-877-KIDS NOW or visit www.insurekidsnow.gov to find out how to apply. Please review the information posted on the Benefits website for more details.

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

As required by the Women's Health and Cancer Rights Act of 1998, this plan provides coverage for

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

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



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HIPAA Notice of Special Enrollment Rights

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

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

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

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

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

Newborns' and Mothers' Health Protection Act of 1996

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



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