Indiana Employers Trust

LET US MAKE YOUR LIFE A LITTLE EASIER.

Partnering with IET gives you more than access to high quality benefits plans at a great price. We take a large amount of work off of your plate with services that make our plans easy to administer, so you can get back to doing what you do best.

BENEFITSOLVER®

This cutting edge technology streamlines the benefits enrollment & eligibility process, including:

CONSOLIDATED BILLING

All benefits information is entered into one system and displayed on a single bill.

EMPLOYEE ACCESSIBILITY

Employees can easily access and edit their eligibility information in the system.

SINGLE POINT OF ENTRY

Reduce your workload by entering information for multiple insurance carriers only once.

BUILT-IN COBRA & HIPAA

COBRA & HIPAA information is processed efficiently alongside other eligibility & enrollment data.

24-HOUR ACCESS

Log into the system from any device, any time of day to view or edit information.

DOCUMENT STORAGE & DELIVERY

Manage records and deliver new hire paperwork, insurance cards, and more with the click of a button.

COMPLIANCEDASHBOARD®

The leading benefits compliance software helps you make sense of compliance while reducing your risk of costly fines and penalties. The simple calendar and email notification system keeps you up to date with ERISA, HIPAA & ACA requirements and more.

ALL-HANDS-ON-DECK CUSTOMER SERVICE

When you have questions, we have answers. Your dedicated account contact invests time in learning about your company and the challenges that are unique to IET members. We strive for rapid resolution and proactive suport, addressing each issue with the care you deserve.

RISK MITIGATION

There's nothing more important to us than safeguarding you from potential risks. From regular audits to secure document transmittal, our processes ensure that nothing slips through the cracks.

IET
Indiana Employers Trust

CAPSTONE
Administrators

AIA Indiana Group Association Employee Benefit Plan

IET Trust Benefits													HSA 10
Plan Name	11 Rx AE	17 Rx V	20 Rx V	23 Rx V	24 Rx V	27 Rx V	27 Rx W	30 Rx W	HSA E0105	HSA E0205	HSA E0305	HSA 08	Rx BI
In Network Benefits													
Individual Deductible	$500	$1,000	$1,500	$1,500	$2,000	$3,000	$3,000	$4,000	$2,650	$4,000	$5,000	$6,450	$2,650
Family Deductible	$1,500	$3,000	$4,500	$4,500	$6,000	$9,000	$9,000	$12,000	$5,300	$8,000	$10,000	$12,900	$5,300
Coinsurance	80%	70%	80%	70%	70%	70%	70%	80%	100%	100%	100%	100%	100%
Individual Max Out of Pocket	$4,000	$4,000	$5,000	$5,000	$5,000	$6,000	$6,000	$6,350	$3,650	$5,000	$6,450	$6,450	$3,425
Family Max Out of Pocket	$8,000	$8,000	$10,000	$10,000	$10,000	$12,000	$12,000	$12,700	$7,300	$10,000	$12,900	$12,900	$6,850
Office Visit Copay	$25	$30	$25	$25	$25	$30	$30	$30	Deductible	Deductible	Deductible	Deductible	Deductible
Specialist Copay	$25	$30	$25	$40	$25	$30	$30	$30	Deductible	Deductible	Deductible	Deductible	Deductible
Urgent Care Copay	$75	$75	$75	$75	$75	$75	$75	$75	Deductible	Deductible	Deductible	Deductible	Deductible
Emergency Room Copay	$250/20%	$250/30%	$250/20%	$250/30%	$250/30%	$250/30%	$250/30%	$250/20%	Deductible	Deductible	Deductible	Deductible	Deductible
Non Network Benefits													
Individual Deductible	$1,000	$2,000	$3,000	$3,000	$4,000	$6,000	$6,000	$8,000	$5,300	$8,000	$10,000	$13,000	$5,300
Family Deductible	$3,000	$6,000	$9,000	$9,000	$12,000	$18,000	$18,000	$24,000	$10,600	$16,000	$20,000	$26,000	$10,600
Coinsurance	60%	50%	60%	50%	50%	50%	50%	60%	70%	70%	70%	70%	70%
Individual Max Out of Pocket	$8,000	$8,000	$10,000	$10,000	$10,000	$12,000	$12,000	$16,000	$10,600	$16,000	$20,000	$26,000	$10,600
Family Max Out of Pocket	$16,000	$16,000	$20,000	$20,000	$20,000	$24,000	$24,000	$32,000	$21,200	$32,000	$40,000	$52,000	$21,200
Prescription Drug Benefits													
Deductible							$250 Deductible	$250 Deductible					
Retail													
Tier 1	$10	$15	$15	$15	$15	$15	$15	$15	Ded then $10	Ded then $10	Ded then $10	Deductible	Ded then $10
Tier 2	$30	$45	$45	$45	$45	$45	$45	$45	Ded then $30	Ded then $30	Ded then $30	Deductible	Ded then $30
Tier 3	$60	$75	$75	$75	$75	$75	$75	$75	Ded then $60	Ded then $60	Ded then $60	Deductible	Ded then $60
Tier 4	25% to $200	25% to $200	25% to $200	25% to $200	25% to $200	25% to $200	25% to $200	25% to $200	Ded then 25%	Ded then 25%	Ded then 25%	Deductible	Ded then 25%
Mail Order													
Tier 1	$10	$15	$15	$15	$15	$15	$15	$15	Ded then $10	Ded then $10	Ded then $10	Deductible	Ded then $20
Tier 2	$75	$115	$115	$115	$115	$115	$115	$115	Ded then $75	Ded then $75	Ded then $75	Deductible	Ded then $90
Tier 3	$180	$225	$225	$225	$225	$225	$225	$225	Ded then $180	Ded then $180	Ded then $180	Deductible	Ded then $180
Tier 4	25% to $200	25% to $200	25% to $200	25% to $200	25% to $200	25% to $200	25% to $200	25% to $200	Ded then 25%	Ded then 25%	Ded then 25%	Deductible	Ded then 25%
Network	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access

AIA Indiana Group Association Employee Benefit Plan - Dental Options

	Plan A - no Ortho	Plan A - with Ortho	Plan B - no Ortho	Plan B - with Ortho	Plan C - no Ortho	Plan C - with Ortho
Calendar Year Maximum	$1,000	$1,500	$1,500	$1,500	$2,000	$2,000
Deductible						
Individual	$50	$50	$50	$50	$50	$50
Family	$150	$150	$150	$150	$150	$150
Preventive	100%	100%	100%	100%	100%	100%
Basic Procedures	80%	80%	80%	80%	90%	90%
Major Procedures	50%	50%	50%	50%	60%	60%
Orthodontic	N/A	50%	N/A	50%	N/A	50%
Ortho Lifetime Maximum	N/A	$1,000	N/A	$1,500	N/A	$2,000
	Employer Paid	**Employer Paid**	**Employer Paid**	**Employer Paid**	**Employer Paid**	**Employer Paid**
Employee Only	$25.95	$25.95	$31.55	$31.55	$37.05	$37.05
Employee & Spouse	$52.95	$52.95	$64.45	$64.45	$75.60	$75.60
Employee & Child(ren)	$62.00	$69.25	$75.45	$85.25	$88.55	$98.35
Employee & Family	$94.15	$102.70	$114.75	$126.20	$134.55	$146.00
	Voluntary	**Voluntary**	**Voluntary**	**Voluntary**	**Voluntary**	**Voluntary**
Employee Only	$29.05	$29.05	$35.35	$35.35	$41.50	$41.50
Employee & Spouse	$59.25	$59.25	$72.20	$72.20	$84.70	$84.70
Employee & Child(ren)	$65.65	$73.35	$80.00	$90.35	$93.85	$104.20
Employee & Family	$99.85	$108.90	$121.60	$133.75	$142.65	$154.80

Employer Paid - 50% employer contribution required towards Employee Rate

AIA Indiana Group Association Employee Benefit Plan - Vision Options

	Low Plan	High Plan
Benefits	**In-Network**	**In-Network**
Exams Copay	$20	$10
Materials Copay	$20	$20
Lenses		
Single	100% after copay	100% after copay
Bifocal	100% after copay	100% after copay
Trifocal	100% after copay	100% after copay
Frames	$130 Allowance, then 20% off remaining balance	$150 Allowance, then 20% off remaining balance
Contacts - Conventional	$130 Allowance, then 15% off remaining balance	$140 Allowance, then 15% off remaining balance
Contacts - Disposable	$130 Allowance	$140 Allowance
Frequency		
Exam	1x per 12 months	1x per 12 months
Materials	1x per 24 months	1x per 12 months
Lenses	1x per 24 months	1x per 12 months
	Employer Paid	**Employer Paid**
Employee Only	$5.04	$6.50
Employee & Spouse	$8.82	$11.37
Employee & Child(ren)	$9.57	$12.34
Employee & Family	$14.61	$18.84
	Voluntary	**Voluntary**
Employee Only	$6.78	$8.85
Employee & Spouse	$11.87	$15.49
Employee & Child(ren)	$12.88	$16.82
Employee & Family	$19.66	$25.67

Employer Paid - 50% employer contribution required towards Employee Rate

Enrollment Application
Group size 2-50 eligible employees

Anthem BlueCross BlueShield AnthemLife

Please complete in black or blue ink for employee and all dependents enrolling with us and return to your employer. Use extra sheets of paper if necessary.
Please provide complete details to avoid delay. Please note that no one will be denied health coverage on an individual basis due to the answers provided below.
All information given should apply to this employer.

Section 1: Type of coverage requested

☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family ☐ Life only ☐ No coverage

Section 2: Enrollment information

☐ Single ☐ Married ☐ Divorced

Relationship	Last name, first name, M.I.	Social Security no.* (required)	Sex	Age	Date of birth (MM/DD/YY)	Height	Weight	Current tobacco user	Disabled
Employee			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
Spouse			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other: _____			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other: _____			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other: _____			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other: _____			☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No

Employee home street address	City	State	ZIP code	County

Employee home phone	Employee work phone	Employee email address

Dependent home street address – if different from employee	City	State	ZIP code	Dependent names

Section 3: Medical information

Please read the Genetic Information Non-discrimination Act (GINA) information in section 11, prior to answering the below questions.

1. Do you or your dependents regularly take medication? ☐ Yes ☐ No
2. Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future? ☐ Yes ☐ No
3. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No
   If yes, name: _____ Due date: ___/___/_____ (MM/DD/YYYY)
4. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? ☐ Yes ☐ No
5. In the last 5 years have you or any of your dependents been diagnosed or treated for any of the following? ☐ Yes ☐ No
   Check all that apply.

☐ Arthritis ☐ Back/disk disorder ☐ Cancer/tumor ☐ COPD ☐ Crohn's disease ☐ Depression, alcohol or drug abuse/dependency ☐ Diabetes (list age of onset below) ☐ Disorder of the blood or immune system ☐ Emphysema ☐ Heart/circulatory condition ☐ Kidney, liver or pancreas disorder ☐ Lung disorder ☐ Lupus ☐ Mental/nervous disorder ☐ Multiple sclerosis ☐ Muscular dystrophy ☐ Stroke, aneurysm ☐ Ulcerative colitis

☐ Other condition: _____

Explain "Yes" answers to any question. Give complete details to avoid delay. Attach a separate sheet of paper if necessary.

Quest. no.	Name of individual	Diagnosis	Treatment	Medication	Onset date	Date(s) of treatment	Hospitalized	Surgery	Recovered
					/ /	/ /	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
					/ /	/ /	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
					/ /	/ /	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
					/ /	/ /	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

*Anthem is required by the Internal Revenue Service to collect this information.

Name	Social Security no.

Section 4: Reason for application

☐ New enrollment ☐ Open enrollment (N/A for Life coverage) ☐ COBRA Event: _____ Date: ☐☐/☐☐/☐☐☐☐ ☐ State Continuation ☐ Waiver	Qualifying event– please complete date and reason. Event date: ☐☐/☐☐/☐☐☐☐ ☐ Marriage ☐ Divorce ☐ Birth of child ☐ Adoption ☐ Terminated employment ☐ Other: _____

Section 5: Group information

Group name		Group no.		Subgroup no.
Group street address	City	State	ZIP code	Full-time hire/rehire date

Employee status ☐ Active ☐ Disabled ☐ Retired ☐ Other: _____	Hours working per week	Occupation	Income reported by ☐ W-2 ☐ 1099 ☐ Other: _____
Annual salary	If not actively at work, reason		Projected return date

Section 6: Coverage selection – Availability dependent upon your employer's offering

Medical coverage – Select one: ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family ☐ No coverage

Check the medical plan you are applying for:

☐ PPO
☐ HMO [1]
☐ POS
☐ Anthem Essential℠ PPO
☐ Traditional
☐ Blue Access® Hospital Surgical POS
☐ HDHP
☐ HDHP/PPO
  ☐ Core
  ☐ Buy Up
☐ PPO/PPO
  ☐ Core
  ☐ Buy Up
☐ Lumenos® Health Savings Account [2]
☐ Lumenos® Health Reimbursement Account
☐ Lumenos® Health Incentive Account
☐ Lumenos® Health Incentive Account Plus

1 If enrolling in an HMO product, please submit a PCP selection form. Anthem's PCP listings can be obtained at anthem.com.
2 Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your employer

Dental coverage – Select one: ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family ☐ No coverage

Vision coverage – Select one: ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family ☐ No coverage

Section 7: Life and disability insurance

☐ Basic Life ☐ Dependent Life ☐ Optional Life: _____ x annual earnings OR $_____ ☐ Current income: $_____ ☐ Hour ☐ Week ☐ Month ☐ Year	☐ Basic AD&D ☐ Optional AD&D	☐ Short Term Disability ☐ Long Term Disability	☐ Anthem by Design® Short Term Disability BUY-UP ☐ Anthem by Design® Long Term Disability BUY-UP ☐ Anthem by Design® Basic Life BUY-UP Complete separate election form.

	Last name	First name	M.I.	Social Security no.	Relationship to applicant	Age
Primary beneficiary						
Contingent beneficiary						

A separate health statement is required for life or disability coverage in excess of Guaranteed Benefit or late enrollment.

Section 8: Waiver of coverage – Must be completed if employee and/or dependents waive medical, vision, dental or life coverage. NOTE: If waiving coverage, please complete this section. Section 12 must also be signed and dated.

Medical coverage declined for – Check all that apply:
☐ Myself ☐ Spouse ☐ Dependent(s)

Dental coverage declined for – Check all that apply:
☐ Myself ☐ Spouse ☐ Dependent(s)

Vision coverage declined for – Check all that apply:
☐ Myself ☐ Spouse ☐ Dependent(s)

Life coverage declined for:
☐ Myself

Reason for declining coverage – Check all that apply:
☐ Covered by spouse's group coverage
Carrier name: _____ ID no.: _____
☐ Enrolled in other Insurance provided by my employer
Carrier name: _____ ID no.: _____
☐ Enrolled in Individual coverage
Carrier name: _____ ID no.: _____
☐ Spouse covered by employer's group medical Coverage
☐ Medicare
☐ Other: _____
☐ No coverage

Name	Social Security no.

Section 9: Prior health insurance information — Prior health care coverage during the past two years (including Anthem)

Insurance company name(s)	Policy no.	Effective date	Cancellation date

Type of prior coverage: ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family ☐ Other: _____

Section 10: Other health insurance information

On the day your coverage begins, will you or a family member be covered by other health insurance coverage and/or Medicare? ☐ Yes ☐ No

Family members covered by other health coverage				
Insurance company name			Policy no.	Effective date
Insurance company street address	City	State / ZIP code		Insurance company phone no.
Policy/certificate holder's name	Social Security no.	Date of birth		Relationship to applicant
Family members covered by Medicare				Medicare ID no.

Part A effective date	Part B effective date	Medicare eligibility reason – Check all that apply ☐ Age ☐ Disability ☐ ERSD – Onset date:		
Medicare Part D carrier		Medicare Part D ID no.	Part D effective date	Part D termination date

Name	Social Security no.

Section 11: Significant Terms, Conditions and Authorizations (TERMS) please read this section carefully before signing the application in section 12.

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Health Savings Account Notice: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of myHealth Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem Blue Cross BlueShield with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem Blue Cross Blue Shield with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem Blue Cross Blue Shield with a written request to revoke my authorization at any time.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program unless required by law.
2. I understand that completion of this form does not guarantee acceptance; eligibility and enrollment criteria must be satisfied (Anthem Life Insurance Company may accept only certain persons or conditions for coverage).
3. If I am declining enrollment for myself or my dependent(s) (including my spouse) because of other health insurance or group health plan coverage, I understand that I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards my coverage or my dependent's other coverage). However, I must request enrollment within 31 days after my coverage or my dependent's other coverage ends (or after the employer stops contribution toward the other coverage).

In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent(s) provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependent or I become eligible for a subsidy (state premium assistance program).

  In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

I certify each Social Security number listed on this application is correct.

I acknowledge I have read the TERMS, and I accept its provisions as a condition of coverage. I represent that all answers are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to coverage or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being rescinded or canceled.

Section 12: Signature required

By signing below, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms. I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem.

Applicant signature	Printed name	Date
X		

Thank you for choosing Anthem Blue Cross and Blue Shield.

ANTHEM USE ONLY – Coordination of benefits? ☐ Yes ☐ No