I’m Dr. Kimberly Roop, plan president at Anthem. I’m a physician and part of a team of dedicated doctors, nurses and other Anthem staff who are here to improve your health and the health of our communities.

Anthem works with the State of Indiana to bring you the Healthy Indiana Plan (HIP) health care program. We’ve been honored to serve Hoosier Medicaid members since 2007. Now that you’re a part of the Anthem family, we want to make sure you make the most of your benefits. This member handbook will tell you how to use your new health plan.

Inside, you will find:
- How your health plan works.
- Services that are part of your plan benefits.
- Programs to help keep you well.
- Helpful phone numbers.
- How HIP Plus members can make payments.
- Help if you don’t understand something or have a problem.
- Your member rights and responsibilities.

We’re committed to helping you get the care you need and deserve. Now that you’re an Anthem member, here are a few things we encourage you to do right away:

Choose HIP Plus, the best value plan that includes vision, dental and chiropractic services.

Select a doctor and make an appointment for a checkup right away.

Complete the Health Needs Screening. See the flier in your member packet for details.

Also remember to keep your member ID card with you at all times. Show it every time you need health care services. If you’re a HIP Plus Plan member, pay your contribution on time every month. Thank you again for choosing us as your health care plan!

Sincerely,

Kimberly Roop, MD
Plan President
# Table of contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intro – Quick Guide</td>
<td>6</td>
</tr>
<tr>
<td>Part 1 – All about the Healthy Indiana Plan</td>
<td>18</td>
</tr>
<tr>
<td>HIP Plus</td>
<td>18</td>
</tr>
<tr>
<td>HIP Basic</td>
<td>19</td>
</tr>
<tr>
<td>HIP State Plan Benefits</td>
<td>19</td>
</tr>
<tr>
<td>HIP Maternity</td>
<td>20</td>
</tr>
<tr>
<td>Pregnancy Care</td>
<td>20</td>
</tr>
<tr>
<td>New Baby, New Life™</td>
<td>21</td>
</tr>
<tr>
<td>CenteringPregnancy®</td>
<td>21</td>
</tr>
<tr>
<td>Baby Shower program</td>
<td>21</td>
</tr>
<tr>
<td>Baby and Me Tobacco Free</td>
<td>21</td>
</tr>
<tr>
<td>Indiana Quitline</td>
<td>21</td>
</tr>
<tr>
<td>Copays in the HIP program</td>
<td>22</td>
</tr>
<tr>
<td>HIP Basic and HIP Plus</td>
<td>23</td>
</tr>
<tr>
<td>Services offered by Anthem</td>
<td>23</td>
</tr>
<tr>
<td>Services not offered by Anthem</td>
<td>25</td>
</tr>
<tr>
<td>Self-referral services</td>
<td>25</td>
</tr>
<tr>
<td>HIP State Plans and HIP Maternity</td>
<td>26</td>
</tr>
<tr>
<td>Services offered by Anthem</td>
<td>26</td>
</tr>
<tr>
<td>Services not offered by Anthem</td>
<td>28</td>
</tr>
<tr>
<td>Self-referral services</td>
<td>28</td>
</tr>
<tr>
<td>Other services</td>
<td>29</td>
</tr>
<tr>
<td>Dental benefits summary</td>
<td>29</td>
</tr>
<tr>
<td>HIP Plus</td>
<td>29</td>
</tr>
<tr>
<td>HIP Basic</td>
<td>29</td>
</tr>
<tr>
<td>HIP State Plan Plus, HIP State Plan Basic and HIP Maternity</td>
<td>30</td>
</tr>
<tr>
<td>Your HIP POWER Account</td>
<td>30</td>
</tr>
<tr>
<td>HIP Plus POWER Account contribution payments</td>
<td>30</td>
</tr>
<tr>
<td>Tobacco surcharge</td>
<td>31</td>
</tr>
<tr>
<td>Five-percent cost-sharing limit</td>
<td>31</td>
</tr>
<tr>
<td>How to make a payment to your POWER Account</td>
<td>32</td>
</tr>
<tr>
<td>POWER Account rollover credit</td>
<td>33</td>
</tr>
<tr>
<td>Monthly POWER Account statement</td>
<td>34</td>
</tr>
</tbody>
</table>
Part 2 – Ways to great health

Choose your primary medical provider
- Services from doctors not in the Anthem plan
Continuity of care
Changing from pediatric care to adult care
Schedule a health checkup
Hoosier Healthwatch
Prepare for your doctor’s visit
Think three for your member ID
Preapproval
Changing your PMP
Specialist care
Standing referral
Getting a second opinion
Indiana Right Choices Program
Behavioral health services
Stay well
WebMD’s Personal Health Record
Disease management
Health homes
Substance use disorder program
Sick or hurt? Where do you go?
- After hours care
- Urgent care
- Emergency care

Part 3 – Pharmacy services

Filling your prescriptions
Pharmacy benefits for HIP members
Generic drugs
Preapproval on drugs
Pharmacy copays
Other important information
- Day’s supply of drugs
- Early refill
- Emergency safety program
- Medication therapy management
- Member medication support
Your appeal rights

Part 4 – Help with special services

Help in other languages
Help for members with hearing or vision loss
Americans with Disabilities Act
Special note to our American Indian and Native Alaskan members

Part 5 – Know your rights and other helpful information

Member rights
Member responsibilities
Making benefit decisions
New medical treatments
Your Benefit Year
Choosing a new health plan
If you have other insurance
What to do if you get a bill from a provider
Privacy policies
Your medical records
Living wills
Quality improvement
Reporting fraud and abuse
If we can no longer serve you

Part 6 – How to resolve a problem with Anthem

If you have a question
Grievances
Appeals
External independent review
Medicaid hearing and appeal process

Notice of Privacy Practices
Healthy Indiana Plan (HIP) Quick Guide

At a glance, find out about:

- Your benefits.
- Important phone numbers.
- Choosing a primary medical provider (PMP).
- Pharmacy services.
- Ways to great health.

### Important phone numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone number</th>
<th>Information</th>
</tr>
</thead>
</table>
| Member Services                                        | 1-866-408-6131 (TTY 711)             | Hours: Monday through Friday, 8 a.m. to 8 p.m. Eastern time. Call for questions about:  
  - Your health plan.  
  - Behavioral health.  
  - Substance abuse services.  
  - Pharmacy benefits.  
  - Utilization management issues. |
| 24/7 NurseLine — toll-free, 24-hour nurse help line    | 1-866-408-6131 (TTY 711)             | Talk in private with a nurse 24 hours a day, seven days a week.                                                                                         |
| Utilization Management (UM)                            | 1-866-408-6131 (TTY 711)             | Hours: Monday through Friday, 8 a.m. to 5 p.m. Call if you have questions about UM or a prior authorization request. You may ask for an interpreter. If after hours, you can leave a private message. Staff will return your call the next business day or at a different time upon request. Staff will identify themselves by name, title and organization when making or returning calls. |
| Anthem Transportation Services                         | 1-844-772-6632 (TTY 1-866-288-3133)  | Set up nonemergency transportation to doctor appointments.                                                                                               |
| National Poison Control Center (Calls are routed to the closest local office.) | 1-800-222-1222                       | Talk with a nurse or doctor for free poison prevention advice and treatment 24 hours a day, seven days a week.                                               |
| Relay Indiana                                           | 1-800-743-3333 (TTY 711)             | For members with hearing or speech loss — a trained person will help them speak to someone using a standard phone.                                         |
| Vision Service Plan (VSP) (Members in the St. Francis Health Network: Please call your primary doctor.) | 1-866-866-5641 (TTY 1-800-428-4833)  | Find an eye doctor in your plan or learn more about your vision benefits.                                                                               |
| Women, Infants, and Children (WIC)                     | 1-800-522-0874                       | Learn more about this program, which gives healthy food to pregnant women and young mothers.                                                            |
| Indiana Family and Social Services Administration (FSSA) | 1-800-403-0864                       | Call this number to report any information changes.                                                                                                    |
Technology at your service

Anthem offers online tools to make it easier for you to access care and services. With our secure member website, you can manage your health care with a few clicks. Just go to our website at www.anthem.com/inmedicaid to set up your secure account. Once you’re registered, you can:

- Choose or change doctors.
- Order a new ID card.
- Check your POWER Account.
- Look at the status of claims.
- Contact Member Services.
- Have messages/communications sent to your account.

It’s easy, and you’ll be able to get things done without the wait. Also, check out these Anthem web pages for special programs:

- **Anthem Rewards**
  - Web address: www.anthem.com/AnthemRewards
  - Details: Offers many rewards for staying healthy.

- **Blue Ticket to Health**
  - Web address: www.anthem.com/blueticket
  - Details: We teamed up with the Indianapolis Colts so you can win prizes for getting your wellness checkup.

- **HIP Plus**
  - Web address: www.anthem.com/GetHipPlus
  - Details: HIP Plus offers the best value with extra benefits and no copays.

- **Anthem Third-Party Payment Center**
  - Web address: www.anthem.com/Pay4HIP
  - Details: For employers and groups, like churches and foundations, who’d like to pay a HIP member’s POWER Account contribution (PAC). This site is for employers and groups only. It is not for HIP members.
**HIP Benefits and Copay Comparison Guide**

<table>
<thead>
<tr>
<th>Service</th>
<th>HIP Plus Plan</th>
<th>HIP Basic Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor care</td>
<td>No copay</td>
<td>Copay</td>
</tr>
<tr>
<td>Hospital services</td>
<td>No copay</td>
<td>Copay</td>
</tr>
<tr>
<td>Lab tests and X-rays</td>
<td>No copay</td>
<td>Copay</td>
</tr>
<tr>
<td>Dental care</td>
<td>No copay</td>
<td>Not covered*</td>
</tr>
<tr>
<td>Vision services</td>
<td>No copay</td>
<td>Not covered*</td>
</tr>
<tr>
<td>Diabetes management training</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>No copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>Family planning</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td>Bariatric (weight-loss) surgery</td>
<td>No copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No copay</td>
<td>Copay</td>
</tr>
<tr>
<td>Emergency care</td>
<td>Copay if not a true emergency</td>
<td>Copay if not a true emergency</td>
</tr>
<tr>
<td>Nurse practitioner services</td>
<td>No copay</td>
<td>Copay</td>
</tr>
<tr>
<td>Transportation — nonemergency</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td>Pharmacy and OTC drug</td>
<td>No copay</td>
<td>Copay</td>
</tr>
<tr>
<td>Urgent care clinic</td>
<td>No copay</td>
<td>Copay</td>
</tr>
</tbody>
</table>

* Covered for members who are pregnant or age 19-20 with no copay.

**Enhanced benefits**

On top of your HIP benefits, and many doctors to choose from, Anthem offers you these extras:

<table>
<thead>
<tr>
<th>Extra Benefits</th>
<th>Details</th>
</tr>
</thead>
</table>
| Cellphone                             | Limited to one per household:  
  - 350 minutes each month  
  - Unlimited texting  
  - One-time bonus of 200 minutes   |
| Weight Watchers®                      |  
  - Membership for up to four months  
  - Referral from your provider/case manager  
  - HIP Plus members only   |
| Gym memberships                       |  
  - Three-month membership  
  - Referral from your provider/case manager  
  - HIP Plus members only   |
| Home-delivered meals                  | Up to five days after your hospital visit:  
  - For members discharged for post-operative recovery or new mothers with babies from the neonatal intensive care unit  
  - One meal per day for five days  
  - Contact your case manager   |
| Pregnancy tests                       | Limit three per year:  
  - Must have prescription  
  - Must be Equate-brand or CVS-brand tests   |
| Test Assessing Secondary Completion (TASC) assistance | To help get your high school equivalency degree:  
  - For members 16 and older and those eligible to take the exam  
  - Covers the cost of the exam  
  - HIP Plus members only   |
| Hypoallergenic bedding                | Must have referral from your provider or case manager   |
| Dental hygiene kits                   | Includes:  
  - Toothbrush kit  
  - Toothpaste  
  - Dental floss   |
| Personal exercise kit                 |  
  - Limit one per member  
  - Referral from your case manager  
  - HIP Plus members only   |
Some of these extra benefits are limited to certain members only. To find out which benefits you may qualify for, call Member Services at 1-866-408-6131 (TTY 711). Benefits may change or end at any time.

For complete benefits, see the Services offered by Anthem section in Part 1.

Healthy Indiana Plan (HIP) benefit plans
- **HIP Plus**: the preferred plan for all members, with extras like dental, vision and chiropractic care and no copays.
- **HIP Basic**: essential, but limited health benefits
- **HIP State plans**: includes some added benefits for certain members
- **HIP Maternity plan**: benefits for pregnant members

See All about the Healthy Indiana Plan in Part 1 for more details.

How do I know what kind of care I need?
We can help you find out. Just take the Health Needs Screening (HNS). Your answers will help us get the right health care for you. To take the HNS, you can use your Anthem Rewards Card at a Walmart Pharmacy kiosk. You can also visit www.anthem.com/hns or call 1-866-408-6131 (TTY 711).

On the path to great health
Follow these easy steps to begin, manage and maintain good health.

- **Choose a doctor** — Your primary medical provider (PMP) is the first person you call for your health care needs.
- **Take the Health Needs Screening** — It helps us get the right care for you. You can earn $10! See the Anthem Rewards Program section in the Quick Guide for details.
- **Schedule a health checkup** — Call your PMP to make an appointment within 90 days of joining Anthem. Get annual checkups even if you do not feel sick. This will help you stay in good health.
- **Prepare for your doctor’s visit** — Decide what you want to discuss and write it down. Be ready to talk about your health history.
- **Review your copays (HIP Basic) and the PAC Tier Table (HIP Plus)** — This way, you’ll be prepared for any health care costs you might have
- **Keep your member ID card close** — Show it every time you need health care services.

Pharmacy services
You can get prescriptions filled at any pharmacy in your plan, including:
- Prescription drugs.
- Over-the-counter (OTC) items.
- Self-injectable drugs (includes insulin).
- Needles, syringes, blood sugar monitors, test strips, lancets and glucose urine testing strips.
- Drugs to help you quit smoking.
Anthem Rewards program

This is Anthem’s way of rewarding members who take steps toward good health. As an Anthem member, you’ll get an Anthem Rewards Card. The first reward is for completing the Health Needs Screening (HNS) within 90 days of joining.

Just take your card to your local Walmart Pharmacy kiosk, scan the card and take the screening. We’ll download $10 to your card for Walmart purchases right there. You can also take the HNS and earn your $10 reward by going online to www.anthem.com/HNS or by calling 1-866-408-6131 (TTY 711).

Be sure to keep your Anthem Rewards Card. There are many other rewards you may qualify for. Go to www.anthem.com/AnthemRewards to find out what other rewards you may be able to earn on your card.

Expanded incentive programs

In addition to our Anthem Rewards program, we offer targeted incentives for members who qualify.

- **Tobacco cessation** — Those who smoke can earn up to $40 for quitting smoking through the Quitline. You’ll get $20 when you sign up and another $20 when you complete the program. Call 1-800-QUIT-NOW (1-800-784-8669) to sign up.
- **Human immunodeficiency virus (HIV) care** — For those with HIV, it’s important to continue taking your medicine to help lower levels of the virus in the body. It also allows you to live longer and reduces the spread of the virus. We’re offering rewards of up to $40 per year for those who take their medicine and have regular lab tests.
- **Diabetic eye exam** — Members with diabetes need to make sure they have a retinal eye exam every year to protect their sight. You’ll earn $20 by getting the exam.
- **Annual wellness exam** — The wellness exam is an important checkup with your doctor. It’s the kind of care you get when you’re not sick. And it helps you stay healthy. Just complete your annual wellness exam, and we’ll give you $20.

For more information about these programs, contact your case manager. Or call Member Services at 1-866-408-6131 (TTY 711).

Blue Ticket to Health — Get in the game

There’s a new game in town — it’s called Blue Ticket to Health! Anthem has teamed up with the Indianapolis Colts to help members age 19 and up be healthy. To take part, call your doctor to set up a wellness checkup. After you complete your checkup, you’ll be entered for a chance to win one of over 500 prizes, including tickets to Colts home games, stadium tours and more. Go to www.anthem.com/blueticket to learn more.

It’s important to see your doctor each year for wellness checkups, even when you’re not sick. It helps the doctor find any health problems early. If you need help setting up a wellness checkup, call Member Services.

Community Resource Link

We provide members access to online resource tools, like the Community Resource Link, so they can find and apply for community and social services in Indiana. Find community-based services in your area the Member Resources page of our website, www.anthem.com/inmedicaid.

Urgent care or emergency room (ER)

When you’re sick or hurt, check the list of symptoms to see where you should go for care. If you need help, call our 24/7 NurseLine at 1-866-408-6131 (TTY 711).

**Urgent care symptoms:**
- Cold, flu, sore throat
- Earaches
- Vomiting or diarrhea
- Common sprain
- Minor broken bone
- Minor cuts
- Mild asthma/allergic reactions
- Rash without fever

**ER symptoms:**
- Chest pain, difficulty breathing
- Head and eye injuries
- Uncontrolled bleeding, severe cuts
- Bad broken bone
- Coughing or vomiting blood
- Bleeding during pregnancy
- Baby under 8 weeks with fever
- Rash with fever

Your primary medical provider

Your primary medical provider (PMP) is the first person you should call for your health care needs. Your PMP coordinates things like:
- Checkups and vaccines.
- Referrals to specialists.
- Referrals for tests and services.
- Admission to a hospital.
Register at Express-Scripts.com and download the mobile app to track your prescription orders, find pharmacies and much more.

HIP members moving to disability or Medicare benefits

During your HIP membership, you may become eligible for Medicare because you turn age 65. You may also become eligible for Medicare due to a disability. In addition to Medicare, there are state programs you may qualify for. Call 1-877-438-4479 or visit www.in.gov/fssa to learn more about disability or other assistance programs that may meet your needs.

What is a POWER Account?

The first $2,500 of your approved health care costs are paid with your Personal Wellness Responsibility Account, also called the POWER Account. HIP Plus members make a small monthly payment (called a contribution) to their POWER Account. But they don’t have copays, like HIP Basic members do.

What is a contribution?

If you’re in the HIP Plus plan, you must make monthly payments to pay your part of the POWER Account. These payments are your contributions. You will get a bill each month for the payment you need to make. Make your monthly payments on time!

Register at Express-Scripts.com and download the mobile app to track your prescription orders, find pharmacies and much more.

Easy ways to pay your HIP Plus POWER Account

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank draft</td>
<td>Have payments taken from your account.</td>
</tr>
<tr>
<td>Online</td>
<td>Register at <a href="http://www.anthem.com">www.anthem.com</a>. Or pay online through your bank.</td>
</tr>
<tr>
<td>Telephone</td>
<td>Call Member Services at 1-866-408-6131 (TTY 711). Allow five days to post to your account.</td>
</tr>
<tr>
<td>MoneyGram</td>
<td>Just go to any MoneyGram location.</td>
</tr>
<tr>
<td>Mail</td>
<td>Anthem Blue Cross and Blue Shield P.O. Box 6431, Carol Stream, IL 60197-6431</td>
</tr>
<tr>
<td>Contributions</td>
<td>From your employer or a non-profit group.</td>
</tr>
</tbody>
</table>

See the section How to make a payment to your POWER Account in Part 1 for more details.

Keep your health care during redetermination

When you first enroll in HIP, you’re eligible for 12 months. After that, you have to renew your benefits every 12 months. This is called your redetermination. If you don’t respond to all paperwork sent to you by the Division of Family Resources (DFR) by the due date, you’ll lose your benefits. You may have to wait six months for your next open enrollment period to apply for HIP again.

Here are the important steps during redetermination:

- About 45 days before the end of your 12-month eligibility period, the State will send you a letter letting you know your eligibility period is about to end.
- If your information has changed since last year, you must return your information to DFR.
- If you’re in HIP Basic, you will have the opportunity to pay for HIP Plus after you renew.

If you don’t follow DFR directions or provide any required updates to your information, you may be disenrolled from HIP. At this point, you still have the opportunity to have HIP without a new application if you send your new information within 90 days from when your benefits ended. If you don’t return information, you’ll have to wait six months from the date your benefits ended to apply for HIP again.

Also, you can choose your health plan each year during the Health Plan Selection Period. See page 53 to learn more.
Part 1 – All about the Healthy Indiana Plan

There are a few different kinds of Healthy Indiana Plan, or HIP, benefit plans.

**HIP Plus**

HIP Plus provides the most benefits, including:
- Vision, dental and chiropractic services.
- 90-day refills on prescriptions you take every day. You can also receive medication by mail.
- Medication therapy management services made to work closely with your doctors and pharmacies to help make sure your prescriptions work safely.

**HIP State Plan benefits**

HIP State plan benefits include some extra benefits for members who are:
- Low-income caretaker, parents, and 19- and 20-year-old dependents.
- Medically frail.

There are two different kinds of HIP State plans. With HIP State Plan Plus, you pay monthly contributions, so you know how much your health care costs. With HIP State Plan Basic, you pay copays, which can add up quickly and cost more.

**Medically Frail**

To be medically frail, you must have a:
- Disabling mental disorder.
- Chronic substance abuse disorder.
- Serious and complex medical condition.
- Physical, intellectual or developmental disability that impairs daily living.
- Disability determination from the Social Security Administration.

If you qualify as medically frail, we’ll need to confirm this each year. For more information or questions about being in the medically frail category, call Member Services at 1-866-408-6131 (TTY 711).

What’s the best deal?

HIP Plus offers the most value — no copays, plus dental, vision, chiropractic services and extra pharmacy benefits! HIP Basic can cost more than paying a monthly contribution to your HIP Plus POWER Account. See the POWER Accounts section in Part 1.

**HIP Basic**

HIP Basic offers essential services, but:
- Does not include everything HIP Plus does.
- Does not provide vision, dental or chiropractic services.
- You’re limited to a 30-day supply of medications and cannot have mail orders.
- Does not provide medication therapy management services.

**HIP State Plan benefits**

HIP State plan benefits include some extra benefits for members who are:
- Low-income caretaker, parents, and 19- and 20-year-old dependents.
- Medically frail.

There are two different kinds of HIP State plans. With HIP State Plan Plus, you pay monthly contributions, so you know how much your health care costs. With HIP State Plan Basic, you pay copays, which can add up quickly and cost more.

**Medically Frail**

To be medically frail, you must have a:
- Disabling mental disorder.
- Chronic substance abuse disorder.
- Serious and complex medical condition.
- Physical, intellectual or developmental disability that impairs daily living.
- Disability determination from the Social Security Administration.

If you qualify as medically frail, we’ll need to confirm this each year. For more information or questions about being in the medically frail category, call Member Services at 1-866-408-6131 (TTY 711).
HIP Maternity plan
If you qualify for HIP and you’re pregnant, or you become pregnant while you’re in HIP,* you’ll be enrolled in the HIP Maternity plan. * With HIP Maternity, you have:
- No copays
- No POWER Account payments during the pregnancy
- Added benefits including rides to doctor appointments
At the end of your pregnancy, you’ll receive an extra 60 days of postpartum benefits. At the end of this period, you will be re-enrolled in HIP Plus.
*As of 2/1/18.
But before the end of the 60-day period, you must do these two things to stay enrolled and keep your HIP Plus benefits:
- Make your required POWER Account contribution.
- Tell the Indiana Family and Social Services Administration your pregnancy has ended. Call 1-800-403-0864 within 10 days after your pregnancy ends.

Pregnancy care
As soon as you know you’re pregnant:
- Call Member Services toll free at 1-866-408-6131 (TTY 711).
- See your doctor for prenatal care — this is the care you get while you’re pregnant. Our staff will make sure your doctor and hospital are in your plan.
- Think about switching to HIP Maternity benefits. You can stay in your current HIP program while you’re pregnant. But, if your 12-month HIP benefit period ends while you’re pregnant, you will be moved to the HIP Maternity plan for the rest of your pregnancy.
- Know that while pregnant, you won’t have to make payments to your POWER Account or have copays for health care services.
- If you need behavioral health care, you can go to any Indiana Health Coverage Programs (IHCP) doctor.

New Baby, New Life™
We’ll send you information on how to take care of yourself during pregnancy, how to prepare for your new baby and after delivery. Sign up by calling 1-866-408-6131 (TTY 711).

CenteringPregnancy®
CenteringPregnancy® is a peer support group, offering women a place to share their feelings and concerns during their pregnancy. A group facilitator guides the discussion and introduces new points of view.

Baby shower program
Anthem partners with groups, such as WIC, to host baby showers around the state to educate pregnant women about their babies. Members will learn about the importance of well-baby visits, how to select a doctor, scheduling appointments and much more.

Baby and Me Tobacco Free
This smoking-cessation program aims to lower the tobacco use of pregnant women. Those who follow these four steps will be eligible for rewards, such as $25 diaper vouchers:
1. Enroll in the program
2. Take prenatal smoking-cessation classes
3. Agree to take a monthly breath test
4. Stay smoke free after their baby is born
Go to www.babyandmetobaccofree.org to find out more. See the Expanded incentive programs section to learn more about earning incentives.

Indiana Quitline
When you’re ready to quit, just call the Indiana Tobacco Quitline at 1-800-QUIT-NOW or 1-800-784-8669 for more information. This service is free for all Indiana residents to help smokers quit. Call Member Services at 1-866-408-6131 (TTY 711) to find out more about signing up for the Quitline. If you’re pregnant, you may be able earn rewards! See the Expanded incentive programs section to learn more about earning incentives.

Prenatal rewards
If you’re pregnant, you could receive gift cards for getting the needed prenatal and postpartum care for you and your baby. To learn more, call Member Services toll free at 1-866-408-6131 (TTY 711) to receive information on our prenatal rewards.
Copays in the HIP program

A copay is the amount you pay each time you go to the doctor or get prescriptions. In HIP, members who are American Indian/Alaska Native, pregnant or who have hit the 5% cost-sharing limit do not have copays.

HIP Basic members have these copays:
- Doctor/outpatient visits: $4
- Inpatient services: $75
- Preferred drugs: $4
- Nonpreferred drugs: $8
- Nonemergency ER visit: $8 — members are not charged if they call the 24/7 NurseLine at 1-866-408-6131 (TTY 711) first and are told to go to the ER.

HIP Plus members don’t have copays, except for nonemergency ER visits as described above.

HIP Basic and HIP Plus

Services offered by Anthem

The services listed below are for members in either HIP Basic or HIP Plus. Copays do not apply to HIP Plus members, except for use of the emergency room when it’s not an emergency.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Details</th>
<th>Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor care</td>
<td>Includes:</td>
<td>Basic: $4 for visits to the doctor and specialists. No copay for preventive care, including wellness exams, screenings and shots.</td>
</tr>
<tr>
<td></td>
<td>- Preventive care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program services, including routine dental, wellness visits and lead screening</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Physical exams</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Immunizations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Specialty care</td>
<td></td>
</tr>
</tbody>
</table>
| Emergency room            |                                                                        | Basic and Plus: $8 for ER use if it is not an emergency.  
*As of 2/1/18          |
| Hospital                  | Inpatient services                                                    | Basic: $75                  |
|                           | Outpatient services and surgeries                                     | Basic: $4                   |
|                           | - Bariatric (weight-loss) surgery is covered under HIP Plus           |                            |
| Lab tests and X-rays      |                                                                        | Basic: $4                   |
| Chiropractic care         |                                                                        |                            |
|                           | - Six spinal therapy visits each year                                  |                            |
|                           | - Limited to one visit per day                                        |                            |
|                           | - Self-referral                                                       |                            |
|                           | - Not covered for HIP Basic members                                   |                            |
| Post-stabilization services|                                                                        |                            |
| Ambulance transportation for emergencies |                                                                      |                            |
| Medical supplies          | Includes:                                                             | Basic: $4                   |
|                           | - Durable medical equipment                                          |                            |
|                           | - Hearing aids                                                        |                            |
|                           | - Orthotics and prosthetic devices                                    |                            |
| Physical, speech, occupational, respiratory, cardiac therapy  | Basic: Up to 60 treatments for each episode per benefit period         | Basic: $4                   |
|                           | Plus: Up to 75 treatments per benefit period                           |                            |
Services not offered by Anthem include:
- Services that are not medically necessary.
- Nursing home (other than short-term) or long-term care facility services.
- Acupuncture.
- Experimental or investigational procedures.
- Care you get in another country.
- Surgery or drugs to help you get pregnant.
- Sex change surgery or treatments.
- Cosmetic surgery (this does not apply to reconstructive surgery).
- Psychiatric state hospital or residential treatment.
- Vitamins, supplements and over-the-counter (OTC) medicines, which are not covered under your pharmacy benefit.
- OTC birth control, except as provided by family planning providers.
- For any condition, disease, defect, ailment or injury that takes place while working if you have workers’ compensation.
- Private duty nursing.
- The evaluation or treatment of learning disabilities.

Self-referral services
You can receive these self-referral services without seeing your PMP to get a referral.
You can see any Indiana Health Coverage Programs (IHCP) doctor for these services:
- Behavioral health
- Emergency services
- Family planning
- Chiropractic care

You can see any Anthem HIP doctor for these services:
- Diabetes self-care training
- Immunizations
## HIP State Plans and HIP Maternity benefits

### Services offered by Anthem

The services listed below are for members in either a HIP State Plan or HIP Maternity. Copays do not apply to HIP Maternity members.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Details</th>
<th>Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor care</td>
<td>Includes: Preventive care, Physical exams, Prenatal care, Well-child checkups, Immunizations, Specialty care</td>
<td>State Basic: $4 for visits to the doctor and specialists. No copay for preventive care, including wellness exams, screenings and shots.</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Up to five visits per year and 50 therapeutic physical medicine treatments per year. Chiropractors are allowed to perform therapy services if licensed.</td>
<td>State Basic: $4</td>
</tr>
<tr>
<td>Emergency room</td>
<td></td>
<td>State Basic and Plus: $8 for ER use if it is not an emergency. *As of 2/1/18</td>
</tr>
<tr>
<td>Hospital</td>
<td>Inpatient services</td>
<td>State Basic: $75</td>
</tr>
<tr>
<td>Lab tests and X-rays</td>
<td>Outpatient services and surgeries</td>
<td>State Basic: $4</td>
</tr>
<tr>
<td>Post-stabilization services</td>
<td></td>
<td>State Basic: $4</td>
</tr>
<tr>
<td>Ambulance transportation for emergencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical supplies</td>
<td>Includes: Durable medical equipment, Hearing aids, Orthopedic shoes and leg braces, Orthotics and prosthetic devices</td>
<td>State Basic: $4</td>
</tr>
<tr>
<td>Therapy services</td>
<td>Physical, speech, occupational and respiratory therapy</td>
<td>State Basic: $4</td>
</tr>
<tr>
<td>Behavioral health</td>
<td>Care for mental health/substance abuse</td>
<td>State Basic: $4</td>
</tr>
<tr>
<td>Prescription services</td>
<td>Provided by Anthem/ESI Includes: Prescription drugs, OTC drugs with a prescription, Diabetic supplies, Specialty drugs (Hepatitis C drugs are paid for by OMPP/OptumRX)</td>
<td>Members enrolled in HIP Basic and HIP State Plan Basic pay $8 copay for nonpreferred, and $4 for preferred prescriptions. There are no pharmacy copays for HIP Plus and HIP State Plan Plus.</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>Includes: One 12-week course of treatment per calendar year, Prescription and OTC medicines, such as nicotine patches or gum, Counseling services (a limit of eight hours of counseling services)</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>HIP Maternity, Up to 60 days per rolling 12-month period</td>
<td>State Basic: $75</td>
</tr>
<tr>
<td>Renal dialysis</td>
<td></td>
<td>State Basic: $4</td>
</tr>
<tr>
<td>Vision services</td>
<td>One exam every 12 months, Glasses every two years, Contact lenses, if medically necessary</td>
<td>State Basic: $4</td>
</tr>
<tr>
<td>Podiatry services</td>
<td>Up to six routine foot care visits per year</td>
<td>State Basic: $4</td>
</tr>
<tr>
<td>Home health care</td>
<td></td>
<td>State Basic: $4</td>
</tr>
<tr>
<td>Nurse practitioner services</td>
<td>A nurse practitioner is a nurse who works with a primary medical provider (PMP).</td>
<td>State Basic: $4</td>
</tr>
<tr>
<td>Nonemergency transportation</td>
<td>Unlimited trips, Anthem also allows trips for: Women, Infants, and Children (WIC) program, Division of Family Resources (DFR), Health education programs</td>
<td></td>
</tr>
</tbody>
</table>

*HIP State Plans and HIP Maternity benefits are offered by Anthem.*

*HIP Basic and Plus includes the following copays: State Basic: $4, State Basic and Plus: $8 for ER use if it is not an emergency.*
Services not offered by Anthem include:
- Services that are not medically necessary
- Nursing home (for more than allowed under plan benefits) or long-term care facility services
- Intermediate Care Facility Services (ICF/MR)
- Services under the Home- and Community-based Services (HCBS) waiver
- Psychiatric state hospital or residential treatments
- Services/care you receive in another country
- Acupuncture
- Experimental or investigational treatments
- Cosmetic surgery (this does not apply to reconstructive surgery)
- Alternative medicine
- Surgery or drugs to help you get pregnant
- Sex change surgery or treatments
- Vitamins, supplements and over-the-counter (OTC) medicines not offered through the pharmacy benefit
- OTC birth control
- Private duty nursing
- For any condition, disease, defect, ailment or injury that takes place while working if you have workers’ compensation
- Hospice care

Self-referral services
You can receive self-referral services without seeing your PMP. You can see any IHCP provider for the services, including:
- Behavioral health
- Chiropractic care
- Diabetes self-care training — you can go to any Anthem HIP provider
- Emergency services
- Eye and vision care
- Family planning
- HIV/AIDS care management
- Podiatry services
- Immunizations

Other services
Indiana Health Coverage Programs (IHCP) covers some types of care for HIP Maternity members. These types of service are called carve-outs. You may get these services from any IHCP-enrolled doctor. Carve-out services include:
- Medicaid Rehabilitation Option (MRO) (also carved out for HIP State Plan members) — offers various mental health services to help members achieve their best health in daily life.
- Individualized Education Plan services — to assist members who need extra help with their education goals.
- 1915i Waiver wrap-around services — includes a number of services for members who may have special needs.

To find out more about these services, speak with your case manager, or call Member Services at 1-866-408-6131 (TTY 711).

Dental benefit summary
Your dentist will tell you if the dental care you need is covered and if there are copays. Your dentist will also help you if you need an OK for dental care. Benefits are based on a treatment code and/or medical necessity.

HIP Plus
- Two exams and cleanings per year
- Bite-wing X-rays once every 12 months and one complete set of comprehensive X-rays every five years
- Up to four extractions or basic restorations such as fillings per 12 months
- One prefabricated (stainless steel or resin) crown per year

HIP Basic
- HIP Basic members who are 19 to 20 years old receive the following dental benefits:
  - Two exams and cleanings per year
  - Bite-wing X-rays once every 12 months and one complete set of X-rays every three years
- All other HIP Basic members, dental benefits are not covered
HIP State Plan Plus, HIP State Plan Basic* and HIP Maternity
- Two exams and cleanings per year
- Bitewing X-rays once every 12 months and one complete set of X-rays every three years
- Minor restorations such as fillings
- Major restorations such as prefabricated crowns (stainless steel or resin) and root canals
- Periodontal care includes deep cleanings and surgical treatment for gum disease
- Partial, full dentures, and repairs to partials and dentures
- Extractions
- Sedation and nitrous oxide if medically necessary

*For members with HIP State Plan Basic: Copay is $4 per type of dental service. For example, for fillings done on the same day, you will owe one $4 copay. There’s no copay for preventive services like exams and cleanings. Members who are American Indian/Alaska Native, pregnant or who have hit the 5-percent cost-sharing limit don’t have copays.

Your HIP POWER Account

With HIP Plus, every member has a savings account called a Personal Wellness and Responsibility Account. It’s called the POWER Account for short. This POWER Account has $2,500 in it. You use this money to pay for your approved health care within the Healthy Indiana Plan.

Where does the money in my POWER Account come from?

If you’re in the HIP Plus plan, the state pays for most of the $2,500 in the POWER Account and you must make payments to your part of the POWER Account. These payments are called contributions and are based on your income. You will get a bill each month for the payment you need to make. Please remember to pay your POWER Account in full.

No other payments are needed, except if you use the ER for a nonemergency situation. Then, you would pay a copay of $8.

If you’re in HIP Basic, the state pays all of the $2,500 in the POWER Account and you don’t pay a monthly contribution. But you pay a copay each time you go to the doctor, have a hospital visit or get prescriptions. These copays range between $4 and $75 and can cost more when compared to a low monthly payment with HIP Plus. And HIP Basic has fewer benefits than HIP Plus as it does not cover vision, dental and chiropractic care.

Your POWER Account contribution

HIP Plus members make a monthly payment called a contribution. This POWER Account contribution or PAC is based on your income. So, the more you make, the more your PAC will be. See the PAC Tiers table below to find the monthly PAC amounts.

Tobacco surcharge

If you use tobacco, you have the first 12 months of your HIP plan to stop using tobacco. If you don’t, you’ll have a higher PAC. Your PAC payment will have a 50% fee added. See the PAC Tiers table to find the monthly PAC amounts with the Tobacco Surcharge added.

Tobacco use includes these products:
- Chewing tobacco
- Cigarettes
- Cigars
- Pipes
- Hookah
- Snuff

We have programs and benefits to help you quit smoking. And you can even earn money for quitting. See the sections Expanded incentive programs and Services offered by Anthem in this handbook to learn more.

When you start your first 12-month HIP benefits year, you’ll have a chance to tell us if you do or do not use tobacco. If you stop using tobacco, you can let us know anytime by calling:
- The enrollment broker at 1-877-GET-HIP-9 (1-877-438-4479) or
- Member Services at 1-866-408-6131 (TTY 711).

If you are listed as a tobacco user and you think it is wrong, you can file an appeal with us to tell us why you think it’s wrong. See Part 6 How to resolve a problem with Anthem in this handbook to find out how to do this.

PAC Tiers Table

<table>
<thead>
<tr>
<th>Federal Poverty Level Tiers</th>
<th>Monthly PAC Single Person</th>
<th>Monthly PAC Spouses</th>
<th>PAC with tobacco surcharge</th>
<th>Spouse PAC when one has tobacco surcharge</th>
<th>Spouse PAC when both have tobacco surcharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 22%</td>
<td>$1.00</td>
<td>$1.00</td>
<td>$1.50</td>
<td>$1.00 &amp; $1.50</td>
<td>$1.50</td>
</tr>
<tr>
<td>23%-50%</td>
<td>$5.00</td>
<td>$2.50</td>
<td>$7.50</td>
<td>$2.50 &amp; $3.75</td>
<td>$3.75</td>
</tr>
<tr>
<td>51%-75%</td>
<td>$10.00</td>
<td>$5.00</td>
<td>$15.00</td>
<td>$5.00 &amp; $7.50</td>
<td>$7.50</td>
</tr>
<tr>
<td>76%-100%</td>
<td>$15.00</td>
<td>$7.50</td>
<td>$22.50</td>
<td>$7.50 &amp; $11.25</td>
<td>$11.25</td>
</tr>
<tr>
<td>101%-138%</td>
<td>$20.00</td>
<td>$10.00</td>
<td>$30.00</td>
<td>$10.00 &amp; $15.00</td>
<td>$15.00</td>
</tr>
</tbody>
</table>

Five-percent cost-sharing limit

Each benefit quarter (or three months), you should not pay more than 5 percent of your household’s income to your POWER Account and any copays. Anthem will track your payments. If we find you have met your 5-percent limit, your PAC invoice will be set to $1 or $1.50 for tobacco users, which you are still expected to pay. Your regular contribution amount and copays will start again at the beginning of the next quarter.

However, if you feel you’ve paid more than 5 percent of your family’s income for the quarter on health care, call us immediately at Member Services at 1-866-408-6131 (TTY 711). You’ll need to show written proof of the amount you paid.
If your income or family size changes
As a HIP member, you must report these changes within 10 days of when the change occurs:
- You move to a new address or change mailing addresses.
- Your family income or family size changes.
- You lose your job, change jobs or get a new job.
- You become pregnant, deliver your baby or when your pregnancy ends.
- You become insured under Medicare.
- Any other change that you think may affect your eligibility or benefits for HIP.

Please send your information to the FSSA Document Center by calling 1-800-403-0864, mailing to FSSA Document Center, P.O. Box 1810, Marion, IN 46952, or submitting a change request through the FSSA Benefits portal at www.in.gov/fssa/dfr.

How to make a payment to your POWER Account
As a HIP Plus member, you must make monthly payments to your POWER Account called contributions. You’ll get a letter from us each month called an invoice. Here are the ways you can make your payment.

1. **Recurring bank draft** — Have your payments taken from your checking or savings account each month. To request a setup form, contact Member Services at 1-866-408-6131 (TTY 711).

2. **Online through your bank** — Talk to your bank if you need help signing up for their online bill pay services. Allow three business days for your payment to be posted.

3. **Online through Anthem** — Register at www.anthem.com/inmedicaid.

4. **Mail** — Send the POWER Account invoice form with your check or money order to: Anthem Blue Cross Blue Shield, P.O. Box 6431, Carol Stream, IL 60197-6431
   Be sure to write your member ID number on your payment. Be sure to send in mail payments with the tear off coupon attached to your invoice. If you’re paying for multiple family members with one check, include all the coupons.

5. **MoneyGram** — Go to any MoneyGram location. You can find them at places like Walmart or CVS. A complete list is online at www.moneygram.com. You’ll need your member ID number, which is located on the front of your ID card; the Company Name, Anthem Healthy Indiana Plan; and/or the five-digit Receive Code, 15204. Be sure to take the payment slip attached to your invoice with you. There’s no charge for this service.

6. **Telephone** — Pay by credit card by calling Member Services. Allow at least five days for your payment to post.

7. **Employer/nonprofit contributions** — Your employer or a nonprofit group, like a church or foundation, can pay some or all of your contribution. If they pay a part of your contribution, you pay what is left.

**POWER Account rollover credit**
The money you pay into your POWER Account will be yours. If there is money left in the account at the end of the year, you can use this money to lower what you owe if you continue in HIP.

**HIP Plus members**
If you get certain preventive care services, you may qualify to double the amount of your POWER Account Contribution (PAC) money left over! This is called a rollover credit. So if your portion of money left over at the end of your benefit year is $10, getting the required preventive care can save you up to $20 in what you pay the following year. *(Note: the amount of your rollover cannot be greater than what you paid in.)*
Monthly POWER Account statement

You will receive a POWER Account statement every month and it will serve as your explanation of benefits (EOB). It’s not a bill. You can also go to www.anthem.com/inmedicaid and log in to view your statement.

The statement includes:
- The amount you have contributed to your account.
- The amount the state has contributed to your account.
- All the claims we have paid.
- The balance in your POWER Account.
- Which claims were paid from POWER Account funds.

After your doctor appointment, your doctor may print out a POWER Account service estimate for you. The estimate will let you know the possible costs of the services you get. Since it’s an estimate, the final costs may be different. But it will give you a good idea of how you’re spending your POWER Account money.

Preventive care services

<table>
<thead>
<tr>
<th>Preventive care services</th>
<th>Male Ages 19-35</th>
<th>Female Ages 19-35</th>
<th>Male Ages 35-50</th>
<th>Female Ages 35-50</th>
<th>Male Ages 50-64</th>
<th>Female Ages 50-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual physical</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammogram</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pap smear</td>
<td>x</td>
<td>45+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol testing*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Blood glucose screen*</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Tetanus-diphtheria screen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Flu shot*</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Vision</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Dental</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

*Every year or as required by your medical needs

HIP Basic members

If you get your preventive care, you may be able to move up to HIP Plus at a discount when you are determined eligible for another benefit period and continue in HIP. The discount reduces your monthly POWER Account contribution in your current benefit period and your monthly contribution payments could be lowered in HIP Plus by up to 50 percent.

You only have to receive one of the preventive services from the list below (including vision and dental as preventive). Ask your doctor today about getting these services based on your age and gender:

Choose your primary medical provider (PMP)

When you join Anthem, we’ll set you up with a doctor, or PMP. You can also choose your own:
- Look inside Anthem’s provider directory to find and choose a PMP.
- Go online at www.anthem.com/inmedicaid and click on Find a Doctor.

Your PMP is the first person you call for all your health care needs. He or she will help you at any time, even after hours, and will respect your cultural and religious beliefs. Your PMP will take care of all your health care needs by coordinating:
- Checkups and vaccines.
- Requests to get an OK to give you services if needed.
- Referrals to specialists.
- Referrals for tests and services.
- Admission to a hospital.

Part 2 – Ways to great health

Choose your primary medical provider (PMP)

When you join Anthem, we’ll set you up with a doctor, or PMP. You can also choose your own:
- Look inside Anthem’s provider directory to find and choose a PMP.
- Go online at www.anthem.com/inmedicaid and click on Find a Doctor.

Your PMP is the first person you call for all your health care needs. He or she will help you at any time, even after hours, and will respect your cultural and religious beliefs. Your PMP will take care of all your health care needs by coordinating:
- Checkups and vaccines.
- Requests to get an OK to give you services if needed.
- Referrals to specialists.
- Referrals for tests and services.
- Admission to a hospital.

HIP Basic members

If you get your preventive care, you may be able to move up to HIP Plus at a discount when you are determined eligible for another benefit period and continue in HIP. The discount reduces your monthly POWER Account contribution in your current benefit period and your monthly contribution payments could be lowered in HIP Plus by up to 50 percent.

You only have to receive one of the preventive services from the list below (including vision and dental as preventive). Ask your doctor today about getting these services based on your age and gender:

Preventive care services

<table>
<thead>
<tr>
<th>Preventive care services</th>
<th>Male Ages 19-35</th>
<th>Female Ages 19-35</th>
<th>Male Ages 35-50</th>
<th>Female Ages 35-50</th>
<th>Male Ages 50-64</th>
<th>Female Ages 50-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual physical</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammogram</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pap smear</td>
<td>x</td>
<td>45+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol testing*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Blood glucose screen*</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Tetanus-diphtheria screen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Flu shot*</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Vision</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Dental</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

*Every year or as required by your medical needs

Monthly POWER Account statement

You will receive a POWER Account statement every month and it will serve as your explanation of benefits (EOB). It’s not a bill. You can also go to www.anthem.com/inmedicaid and log in to view your statement.

The statement includes:
- The amount you have contributed to your account.
- The amount the state has contributed to your account.
- All the claims we have paid.
- The balance in your POWER Account.
- Which claims were paid from POWER Account funds.

After your doctor appointment, your doctor may print out a POWER Account service estimate for you. The estimate will let you know the possible costs of the services you get. Since it’s an estimate, the final costs may be different. But it will give you a good idea of how you’re spending your POWER Account money.

Choose your primary medical provider (PMP)

When you join Anthem, we’ll set you up with a doctor, or PMP. You can also choose your own:
- Look inside Anthem’s provider directory to find and choose a PMP.
- Go online at www.anthem.com/inmedicaid and click on Find a Doctor.

Your PMP is the first person you call for all your health care needs. He or she will help you at any time, even after hours, and will respect your cultural and religious beliefs. Your PMP will take care of all your health care needs by coordinating:
- Checkups and vaccines.
- Requests to get an OK to give you services if needed.
- Referrals to specialists.
- Referrals for tests and services.
- Admission to a hospital.
Your PMP can be a/an:
- Family or general practitioner, a doctor who takes care of babies, children and adults.
- Internist, a doctor who takes care of adults.
- Obstetrician/gynecologist (OB/GYN), a doctor who takes care of women only.
- Doctor at a clinic such as a health department, federally qualified health center or rural health clinic.
- Nurse practitioner, a nurse who works with your PMP.
- Pediatrician, a doctor who takes care of members under age 21.

If you need a provider directory or help choosing a doctor who is right for you, call Member Services at 1-866-408-6131 (TTY 711).

Services from doctors who are not in the Anthem plan
Call your PMP or Member Services to find out if you need an OK from a provider who is not in your plan. We can only give an OK for providers that are part of the Indiana Health Care Programs (IHCP), which means they are part of the state’s plan.

If you get a service from a doctor that is not in our plan or the service is not approved, it’ll be considered an out-of-plan service. This doesn’t apply to some self-referral services. You may be able to see a doctor who is not in our plan for self-referral (See the section Self-referral services for more details).

How do I find a provider?
Our provider directory and provider finder tools tell you these things:
- Names and addresses of health plan providers
- Phone numbers and office hours
- If the provider is a man or a woman
- What language they speak
- Hospitals where they can work
- If they take new patients
- Where they are (using an online map)

Continuity of care
We’re here to help new members get continuing care and coordination of medically necessary health care when they join Anthem. If you want to know if continuity of care is for you, call Member Services.

Changing from pediatric care to adult care
Did you know you can switch doctors when you get older? If you were an adolescent and reached adulthood, you can switch from your current pediatrician (child doctor) to a provider who cares for adults. We’ll be happy to help you choose a provider for adults. We can also help you transfer your medical records. Please call Member Services at 1-866-408-6131 (TTY 711), Monday through Friday, from 8 a.m. to 8 p.m.

Are there other times I should visit my PMP?
You should visit your doctor once a year for a checkup — even if you don’t feel sick. To help you remember, schedule your checkup in the same month as your birthday each year.

Schedule a health checkup
Call your PMP’s office to make an appointment for a checkup. Tell them you’re an Anthem member. When you make an appointment with your PMP to get a checkup, your PMP will:
- Get to know you and discuss your health.
- Get your medical history from you.
- Help you understand your medical needs.
- Teach you ways to help make your health better or help you stay healthy.
- Schedule any needed tests and preventive services.

Hoosier HealthWatch — Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
We offer EPSDT services for those up to 21 years of age, including members ages 19 and 20 enrolled in any HIP product. You or your family member can be healthy if you:
- Go to your PMP for routine visits and vaccines (shots).
- Go to your dentist and eye doctor for checkups.

Protecting your family from lead poisoning
All members enrolled in Medicaid should have had a blood lead level (BLL) test since age 1 or by age 6, if they’re at risk. If you check one or more of the boxes below, you or your family member must take a BLL test right away. Do you or your family member:
- Visit or live in a house built before 1978 (such as the home of a relative or babysitter, a day care center, or a preschool)?
- Visit or live in a house built before 1978 that is being or will be remodeled?
- Have a brother, sister or friend who has had lead poisoning?
- Visit or live in a house that has chipping, peeling, dusting or chalking paint?
- Often visit an adult who works with lead (such as pottery, painting, construction or welding)?

See the Preventive Health Guidelines on www.anthem.com/inmedicaid to learn more about wellness visits and shots.
Prepare for your doctor’s visit

- Decide what you want to talk about and write down your questions or concerns.
- Be prepared to talk about you and your family’s health history.
- Bring a list of any medications you’re taking or bring them with you.
- Check your current medications and make sure you’re taking them correctly.

Think three for your member ID

We give all of our members an identification (ID) card. Your ID card is very important. Remember these three things:

1. Keep your member ID card with you at all times. Your ID card shows you’re an Anthem member and shows you have the right to get health care.
2. Show this ID card every time you need health care services. Only you can get health care services with your ID card. Don’t let anyone else use your card.
3. If you lose your card, ask for a replacement card. Just log in at www.anthem.com/inmedicaid. Or you can call 1 866-408-6131 (TTY 711).

Preapproval (an OK from Anthem)

Your PMP will need to get an OK from us for some services to make sure they’re offered. This means that both Anthem and your PMP or specialist agree the services are medically necessary. We may ask your doctor why you need special care.

Getting an OK will take no more than seven calendar days or, if urgent, no more than three days.

We may not OK payment for a service you or your doctor asks for. If so, we’ll send you and your doctor a letter that explains why. The letter will let you know how to appeal our decision if you disagree with it. See the Appeals section in Part 6.

If you have questions, you or your doctor may call us at Member Services or the 24/7 NurseLine; see Important phone numbers. Or write us at: Anthem Blue Cross and Blue Shield, P.O. Box 62509, Virginia Beach, VA 23466

Changing your PMP

It is best to keep the same PMP. He or she knows your health needs. If you choose to see a doctor who is not your PMP without an OK from us first, you may have to pay for the services.

If you want to change your PMP, you can quickly do it online at www.anthem.com/inmedicaid. Log in to access your secure account and change your PMP. If you don’t have a secure account, you can create one at any time by clicking Register. You’ll need your member ID number located on your member ID card.

Specialist care

- Your PMP may send you to a specialist for special care or treatment.
- Your PMP will help choose a specialist to give you the care you need. You may not need an OK from us. Your PMP knows when to ask for an OK.
- Your PMP’s office staff can help you. They can set the day and time for the office visit with a specialist.
- Tell your PMP and the specialist as much as you can about your health.
- Any specialist or other provider not in the Anthem health plan must get an OK from us before they can give you care. You may also need a referral from your PMP.

Standing referral

Anthem sometimes lets members get what’s called a standing referral. This means if you need special care or ongoing treatment, you can keep seeing the same specialist. Your doctor will make this referral. The treatment given by the specialist must be right for your health issue and needs. To learn more about this, call Member Services at 1 866-408-6131 (TTY 711).

Getting a second opinion

If you have questions about care your doctor says you need, you may want a second opinion to make sure the treatment plan is right for you. To get a second opinion, talk to your PMP or call Member Services at 1 866-408-6131 (TTY 711).

Indiana Right Choices program

If you’re enrolled in this program, we’ll send you a letter to let you know. A team of experts will help you get the right health care at the right time in the right place. Your team will be made up of a PMP, a pharmacy, a hospital and a care manager. If you have questions about the Right Choices program, call Member Services at 1-866-408-6131 (TTY 711).

Behavioral health services

We offer services for mental health, behavior problems and addiction. You don’t need a referral from your PMP to see someone for these services. Anthem customer service can help you find a doctor in your area. We cover:

- Inpatient services in a hospital.
- Partial hospitalization.
- Intensive outpatient program.
- Individual, family and group therapy.
- Applied behavior analysis.
- Medication services.
- Psychological testing.
Stay well

Each person has special needs at every stage of life. We have programs to help you stay healthy and manage illness. These programs are at no cost to you.

For women
- Well-woman care includes getting exams such as annual checkups, mammograms and cervical cancer screenings.
- Family planning can teach you about healthy pregnancy, preventing pregnancy or preventing sexually transmitted infections (STIs) such as HIV/AIDS.
- Pregnancy and childbirth classes to help you stay healthy while you’re pregnant.
- 24/7 NurseLine provides support for moms-to-be and new mothers who have questions about breastfeeding.

For men
- Male health care includes regular screenings such as Body Mass Index (BMI), blood pressure and diabetes.
- Immunizations such as Tetanus and the flu can keep you well.
- Special screenings for men such as prostate cancer and abdominal aortic aneurysm.

Case management

Health care can be overwhelming, so we’re here to help you stay on top of it. Your case manager will help you:
- Figure out your care plan.
- Answer questions.
- Get you to the services you need.
- Coordinate with your doctors and support system.

If you’ve experienced a critical event or health issue that is complex, we’ll help you learn more about your illness and develop a plan of care through our complex case management program.

Access to complex case management

We use data to find out which members qualify for our complex case management program. You can be referred to complex case management through our:
- 24/7 NurseLine.
- Disease management program.
- Discharge planner.
- Utilization management.
- Member or caregiver referral.
- Your doctor or other provider.

If you have one of these health issues or another complex or special health issue and want to learn more about case management, call Member Services at 1-866-408-6131 (TTY 711).

WebMD’s Personal Health Record

We’ve partnered with WebMD Health Services to provide WebMD’s Personal Health Record (PHR). WebMD’s PHR will serve as a bank of your health information, using Anthem’s clinical data and any health information you add. By giving you the information you need in one place, you’ll be able to make better decisions about your benefits, treatment and doctors in your plan.

Disease management

Our disease management program helps guide the care for our members with chronic health conditions. The program is voluntary, private and available at no cost to you from the Disease Management Centralized Care Unit (DMCCU) team. Our team of licensed nurses, called DMCCU case managers, will help you understand your condition and help you meet health care goals through education, resources and referrals to providers for care.

You can join the program if you have one of these conditions:
- Asthma
- Depression
- Pregnancy
- ADHD
- Autism/PDD
- COPD
- Coronary artery disease
- Chronic kidney disease
- Congestive heart failure
- Hypertension
- Diabetes
- HIV/AIDS
- Schizophrenia
- Bipolar disorder
- Substance use disorder
As a member in the disease management program, you’ll benefit from having a case manager who:

- Listens to you and takes the time to understand your specific needs.
- Helps you make a care plan to reach your health care goals.
- Gives you the tools, support and community resources that can help you improve your quality of life.
- Provides health information that can help you make better choices.
- Helps you coordinate care with your providers.

For more information, visit www.anthem.com/inmedicaid and select Manage Your Condition under the Care tab. You can also call 1-888-830-4300 or the Behavioral Health Crisis Line at 1-866-408-7187.

Health homes

Anthem and the Indiana Central Region Easter Seals are proud to offer the Health Homes program for members with moderate-to-severe autism spectrum disorder (ASD). Health homes coordinate care with the member’s PMP, physical and behavioral specialists, as well as schools and social services to offer full support.

Health homes help members with:

- Care planning.
- Developmental skills.
- Health promotion activities.
- Disease management programs.
- Transition support.

Autism spectrum disorders program

Families touched by autism can speak with counselors from our autism spectrum disorders (ASD) program. We offer a support system to help families understand the care that’s available. Our goal is to help children with ASD live a healthier life with their families. End callout

Substance use disorder program

Anthem’s substance use disorder (SUD) program helps members with major substance use issues improve their overall health. Our care managers work with you to identify long-term goals, helping you strive for a healthier lifestyle.

Improving access to care through LiveHealth Online

This is an easy-to-use option for nonemergent care. When you call the 24/7 NurseLine, they’ll see if a virtual meeting with a doctor would be beneficial.

Urgent or emergency care?

Which do I choose?

See the section Urgent care or emergency room (ER)? for a list of symptoms. It’s in the Quick Guide at the beginning of this handbook.

Sick or hurt? Where do you go?

After-hours care

An urgent medical condition is not an emergency, but needs medical care within 24 hours. It’s not the same as a true emergency. Call your PMP if your condition is urgent, and you need medical help within 24 hours. If you cannot reach your PMP, call our 24/7 NurseLine, even on holidays, at 1-866-408-6131 (TTY 711).

Urgent care

If you have an injury that could turn into an emergency if not treated within 24 hours, you need urgent care. Call your PMP or the 24/7 NurseLine if you have questions.

Emergency care

An emergency is a medical condition with such severe symptoms that you reasonably believe not getting medical attention right away may be life-threatening or cause serious damage to you or your unborn child.

If you have an emergency, call 911 or go to the nearest ER. Make sure to call your PMP within 24 hours after you go to the ER or if you’ve checked into the hospital. Your PMP will set up a visit with you for follow-up care.

Getting emergency care outside our service area

If you need emergency care while you’re traveling outside of our service area, follow these steps to help make sure you’re covered:

- Call your PMP or have the hospital call your PMP if you need surgery or admission to the hospital, or any other services after you’re stable
- Show your ID card to the hospital or doctor
Pharmacy benefits for HIP members include:
- Prescription drugs.
- Over-the-counter (OTC) items approved by the Food and Drug Administration and listed on the OTC medication list.
- Self-injectable drugs (includes insulin).
- Needles, syringes, blood sugar monitors, test strips, lancets and glucose urine testing strips.
- Drugs to help you quit smoking.

Generic drugs
Generic drugs are as good as brand-name drugs. Your pharmacist will give you generic drugs when your doctor has approved them. Here are a few things you need to know:
- By law, generic drugs must be given when there is one available.
- Brand-name drugs may be given if there is not a generic drug for it.
- The PDL will tell you the exceptions to these rules.
- Generic and preferred drugs must be used for your condition unless your doctor gives a medical reason to use a different drug.

Preapproval for drugs
Some drugs need a preapproval, or an OK, ahead of time. Your doctor must ask for an OK if:
- A drug is listed as nonpreferred on the PDL.
- Certain conditions need to be met before you get the drug.
- You’re getting more drugs than what is normally expected.
- There are other drugs that should be tried first.

If an OK is needed, your doctor will need to give us details about your health. We will then decide whether Indiana Health Coverage Programs (IHCP) can pay for the drug. This is important because:
- You may need tests or help with a drug.
- You may be able to take a different drug.

Your doctor can find the phone number for preapproval requests on your ID card. IHCP or Anthem will decide if your drug request can be approved within 24 hours after getting your request (not including Sundays or some holidays). Your doctor will be notified.
Member medication support
To support members who’ve recently visited the emergency room, we send surveys to gather information about your experience and reasons for the visit. If your visit was related to a medication issue, we’ll send a letter about the medications and how to appropriately take them.

Your appeal rights
If your drug request is denied, you or your provider can appeal this decision. You may ask for a Medicaid hearing and appeals review if IHCP or Anthem:
- Denied you a service.
- Reduced a service.
- Ended a service that was approved before.
- Failed to give you timely service.

To ask for a review, you must send a letter to the Medicaid agency within 30 business days of getting our decision about your denial. Send your letter to:
FSSA Hearings and Appeals, RM E034 – IGC-S, MS04, 402 W. Washington St., Indianapolis, IN 46204
A judge will hear your case and send you a letter with the decision within 90 business days after the date that you first asked for the hearing.

Pharmacy copays
HIP members in the Basic Plan have these copays:
- $4 for generic drugs
- $8 for brand-name drugs

There is no pharmacy copay for:
- HIP Plus members.
- Women in the HIP Maternity plan.
- American Indian/Alaska Native members.
- Members who have spent 5 percent of their income for copays and/or contributions.
- Drugs given as an emergency supply.

Other things you need to know about your medication

Days' supply of drugs
HIP Basic or HIP State Basic members may only receive up to a 30-day supply of a drug. HIP Plus or HIP State Plus members may receive a 30-day supply of nonmaintenance drugs or a 90-day supply of maintenance drugs. You can also get a 90-day supply in the mail or at the drugstore. As a value-added benefit, HIP Plus members can set up their 90-day refills for a single date. Through this process, you can make one trip to the pharmacy to pick up all your medications. To help members even more, Anthem will transport you to the pharmacy four times per year to pick up your medications.

Early refills
Your pharmacist will have to ask for an OK ahead of time if you want to get your prescription refilled early. Do not wait until you’re out of a drug to ask for a refill. Please call your doctor or pharmacy a few days before you run out of your drug.

Emergency safety programs
Through Emergency Safety Communications, we alert you and your doctors about significant safety-related drug recalls or market withdrawals.

Medication therapy management
We offer a Medication Therapy Management program through our Personal Medication Coach program to HIP Plus members who qualify. It helps make sure you get the most benefit from your drugs.
Help for members with hearing or vision loss

Call our toll-free Member Services at 1-866-408-6131 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m. Eastern time. If you need help between 8 p.m. and 8 a.m. or on weekends, call Relay Indiana at 1-800-743-3333 (TTY 711).

Americans with Disabilities Act

We meet the terms of the Americans with Disabilities Act (ADA) of 1990. This act protects you from discrimination by us because of a disability. If you believe you have been treated differently because of a disability, please call Member Services toll free at 1-866-408-6131 (TTY 711).

Special note to our American Indian and Native Alaskan members

Thank you for choosing HIP. You have a choice to receive traditional Medicaid benefits instead of HIP. You can call the Family and Social Services at 1-800-403-0864, or complete a Change Form to change from HIP to traditional Medicaid. It won’t cost anything to change, and you may receive more benefits from traditional Medicaid than from HIP.

Part 4 – Help with special services

Help in another language

We offer no-cost services and programs that meet many language and cultural needs and help give you access to quality care. We use an interpreter service that works with more than 140 languages. We offer:

- Health education materials translated into different languages.
- Member Services staff able to speak other languages.
- 24-hour access to telephone interpreters.
- Sign language and face-to-face interpreters.
- Doctors who speak other languages.
- Translation for you while you’re at your primary medical provider’s (PMP’s) office.

Call Member Services at least 72 hours in advance if you need an interpreter or translator at your PMP’s office.

When did the ADA become law?

The Americans with Disabilities Act (ADA) was signed into law on July 26, 1990, by President George H.W. Bush. The 25th anniversary of the ADA was celebrated in 2015.
Part 5 – Know your rights and other helpful information

Member rights
As a member of this health plan, you have the right to:

- Receive information about Anthem, the services we provide, doctors and facilities in your plan and your rights and responsibilities. You can find information about Anthem on our website at www.anthem.com/inmedicaid. You can also call Member Services at 1-866-408-6131 (TTY 711).
- Be treated with respect and with due consideration for your dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a way that is right for your condition and that you can understand.
- Know if your doctor takes part in a physician incentive plan through Anthem. Call us to learn more about this.
- Take part in all decisions about your health care. This includes the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal laws on the use of restraints and seclusions.
- Request and receive a copy of your medical records. And you may request they be amended or corrected, as stated in state and federal health care privacy laws.
- Have timely access to covered services and medically necessary care.
- Have honest talks with your doctors about the right treatment for your condition, in spite of the cost.
- Have your health plan, doctors and all of your care providers keep your medical records and health insurance information private.
- Have your problems taken care of quickly. This includes things you think are wrong, as well as issues that have to do with your benefits, payment of services or getting an OK from us.
- Have access to medical advice from your doctor, either in person or by phone, 24 hours a day, seven days a week. This includes emergency or urgent care.
- Get interpreter services at no charge if you speak a language other than English or if you have hearing, vision or speech loss.
- Ask for information and other Anthem materials (letters, newsletters) in other formats. These include Braille, large-size print or audio CD, at no charge to you. Call Member Services at 1-866-408-6131 (TTY 711).
- Tell us what you would like to change about your health plan.
- Question a decision we make about the care you got from your doctor. You will not be treated differently if you file a complaint.
- Ask about our quality program and tell us if you would like to see changes made.
- Ask us how we do utilization reviews and give us ideas on how to change it.
- Know you will not be held liable if your health plan becomes insolvent (bankrupt and cannot pay its bills).
- Know that Anthem, your doctors or your other health care providers cannot treat you differently for these reasons:
  - Your age
  - Your sex
  - Your race
  - Your national origin
  - Your language needs
  - The degree of your illness or health condition
Member responsibilities
As a member of this health plan, you have the responsibility to:
- Tell us, your doctor and your other health care providers what they need to know to treat you.
- Understand your health problems, and take part in developing shared treatment goals, to the best degree possible.
- Follow the treatment plans you, your doctors and your other health care providers agree to.
- Do the things that keep you from getting sick.
- Treat your doctor and other health care providers with respect.
- Make appointments with your doctor when needed.
- Keep all scheduled appointments and be on time.
- Call your doctor if you cannot make it to your appointment.
- Always call your PMP first for all of your medical care (unless you have an emergency).
- Show your ID card each time you get medical care.
- Use the emergency room only for true emergencies.
- Pay any required copays.
- Pay your monthly contribution payment on time (if you’re a HIP member who is required to pay.)
- Tell us and your social worker if:
  - You move.
  - You change your phone number.
  - You have any changes to your insurance.
  - The number of people in your household changes.
  - You become pregnant.

Making benefit decisions
At Anthem, we care about you and want to help you get the health care you need. We do not give incentives for service denials and we only make decisions based on appropriateness of care and available benefits. Your doctors and other health providers work with you to decide what's best for you and your health. Your doctor may ask us for our OK to pay for a certain health care service. We base our decision on two things:
- Whether or not the care is medically necessary.*
- What health care benefits you have.

We do not pay or reward doctors or other health care workers to:
- Deny you care.
- Say you do not have benefits.
- Approve less care than you need.
* Medically necessary means Anthem will pay for services needed to:
- Protect your life.
- Keep you from getting seriously ill or disabled.
- Reduce severe pain through the diagnosis or treatment of disease, illness or injury.

New medical treatments
We want you to benefit from new treatments, so we review them on a routine basis. A group of PMPs, specialists and medical directors decide if a treatment:
- Is approved by the government.
- Has shown in a reliable study how it affects patients.
- Will help patients as much as, or more than, treatments we use now.
- Will improve the patient's health.

The review group looks at all of the details. The group decides if the treatment is medically necessary. If your doctor asks us about a treatment the review group has not looked at yet, the reviewers will learn about the treatment. They'll let your doctor know if the treatment is medically necessary and if we approve it.

Your benefit year — mark your calendar
HIP now matches your health plan choice to the calendar year. Each fall, during the Health Plan selection period between November 1 and December 15, you’ll have the chance to pick the health plan you’ll stay with all year, from January through December. This is called your Benefit Year. You’ll stay with the same health plan all year, even if you leave HIP and come back during the year.

The good news is, if you like Anthem, you don’t have to do anything! You will be automatically re-enrolled with us for next year.

If you want to make a change, you can call the enrollment broker at 1-877-GET-HIP-9 (1-877-438-4479) between November 1 and December 15 to let them know you want to pick a new health plan for the next Benefit Year. If you were unable to take part in this health plan selection period because you were in a different program, had a lockout, or were not fully enrolled in HIP, you have 30 days to choose a new plan. Just call the enrollment broker and tell them that you want to change health plans because you were unable to take part in the selection period.

This does not change your eligibility period for the program during your redetermination. You still have to go through your redetermination process every 12 months. This will occur based on what month you started with HIP.
Choosing a new health plan

HIP members may change to a different HIP plan for any reason during the first 30 days of health plan membership or until making the first HIP Plus payment, whichever comes first — unless the member has a previous health plan already assigned for the current calendar year.

You can also change health plans “for cause” at any time if:

• You receive poor quality of care or if there are other instances that are determined to be poor quality of care.
• We can’t provide covered services.
• We fail to comply with certain medical standards and practices.
• There’s a lack of access to providers experienced in dealing with your health care needs.
• There are big language or cultural barriers.
• Anthem is being punished for something we did.
• You have limited access to primary care clinics or other health services near you.
• Another managed care entity (MCE) has a list of drugs that’s better for your health care needs.
• You don’t have access to medically necessary services offered by Anthem.
• A service is not covered by us for moral or religious reasons.
• You need a group of related services at the same time and not all related services are available in our health plan, and your provider says getting the services separately will be a risk to you.
• Your PMP leaves Anthem and re-enrolls with another MCE.
• Other circumstances determined by the Office of Medicaid Policy and Planning or its designee to constitute poor quality of health care benefits.

If you have other insurance

Call us at 1-866-408-6131 (TTY 711) if you or your children have other health benefits. This helps us work with your other insurance company to correctly pay claims. Also call us if you:

• Have a workers’ compensation claim.
• Are waiting for a decision on a personal injury or medical malpractice lawsuit.
• Have a car accident.
• Become eligible for Medicare.

What to do if you get a bill from a provider

In most cases, you should not get a bill from a provider. But you may have to pay charges if:

• You agreed in writing ahead of time to pay for care that is not offered by Anthem after you asked for an OK from us.
• You agreed ahead of time in writing to pay for care from a provider who does not work with us, and you did not get our OK ahead of time.

If you get a bill and you do not think you should have to pay for the charges, call Member Services at 1-866-408-6131 (TTY 711). Have the bill with you when you call and tell us:

• The date of service.
• The amount being charged.
• Why you’re being billed.

Privacy policies

Anthem has the right to get information from those who give you care. We use this information so we can pay for and manage your health care. We keep this information private between you, your health care provider and Anthem, except as the law allows. Refer to the Notice of Privacy Practices to read about your right to privacy. This notice was included at the end of this member handbook.

Your medical records

Federal and state laws allow you to see your medical records. Ask your PMP for your records first. If you have a problem getting your medical records from your doctor, call Member Services at 1-866-408-6131 (TTY 711).

Living wills (advance directive)

A living will or advance directive is a legal document that describes how you want to be treated if you cannot talk or make decisions for yourself. You can name someone else as the person who will make decisions about your health care if you’re unable.

You may also want to list the types of care you do or do not want to get. For example, some people do not want to be put on life-support machines if they go into a coma. Your PMP will make sure your living will is in your medical records.

You may change or revoke your living will at any time by telling your PMP or other health care provider. You may file a complaint with the state survey and certification agency if you believe your doctor is not meeting the terms of your living will. Ask your family, PMP or someone you trust to help you. The forms you need are at office supply stores or a lawyer’s office.
Quality improvement

You deserve high quality medical and behavioral health care. Anthem’s Quality Improvement program reviews the services you get from Anthem doctors, hospitals and other health care services. This ensures you receive care that is of good quality, helpful and right for you.

Your health is important to us, and we believe quality work yields quality results. We make information about our quality improvement program available every year on our website and in writing to members upon request and we work hard to make sure you have access to great care. We do this by:

- Having programs and services to help improve your quality of health care.
- Providing learning tools on pregnancy and newborn care for all pregnant members and new moms.
- Finding programs in your community that help you get services, if you need them.
- Hosting learning events to answer your questions and concerns and help you make the most of your health care.
- Following state and federal guidelines.
- Looking at our quality results to find new ways for better care.

Want to know more about our Quality Management program? Would you like to know how it works and how we’re doing? Call Anthem at 1-866-408-6131 (TTY 711). Ask us to mail you Quality Management program information. We can also tell you more about the ways Anthem makes sure you get quality health care services.

You can review the quality and cost of care, as well. This can help you make the best decisions about your care. Visit these sites online to help you find out more:

- The Leapfrog Group — leapfroggroup.org
- Hospital Compare — www.hospitalcompare.hhs.gov
- Physician Quality Information — Indiana Health Information Exchange — www.ihie.org

Your opinion is important to us. You’ll receive a member satisfaction survey each year. Your answers are anonymous. This information is used to improve our services and your care. If we helped you, please tell us in the survey.

You can also be part of our Community Member Advisory Committee (CMAC). As part of this group, you can tell us your views and ideas to help us understand what our members need. It’ll also help us to find out how we can improve the quality and cost of health care.

Reporting member or provider fraud and abuse

If you know someone who is misusing (through fraud, waste, abuse and/or overpayment) any Anthem program, you can report him or her.

To report doctors, clinics, hospitals, nursing homes or Anthem members, write or call us at:

Anthem Medicaid Special Investigations Unit
4425 Corporation Lane
Virginia Beach, VA 23462
1-877-725-2702 (TTY 1-866-494-8279)

Suspicions of fraud, waste and abuse can be emailed directly to the Anthem Medicaid Special Investigations Unit at corpinvest@anthem.com.

If we can no longer serve you

We can’t keep you as a member of the health plan if you:

- Lose your eligibility.
- Are disenrolled from (no longer a member of) the HIP program.
- Move out of Indiana.
- Were signed up in error.
- Become eligible for Medicare.

You can disenroll from HIP at any time. If you want to continue with your health benefits, but disenroll from Anthem, there are certain rules. (See section called Choosing a new health plan.)
If you have a question

If you’re not happy with the care you get from one of the doctors in your plan, please let us know. There are two ways you, or someone you choose to act for you, can let us know your problem:

- Call us at 1-866-408-6131 (TTY 711).
- Send us a letter at:
  Anthem Blue Cross and Blue Shield
  P.O. Box 62429
  Virginia Beach, VA 23466

Our Member Services staff will try to take care of your problem right away. They may have to send the information to the right staff person for a final answer. You may choose not to be named when you tell us, or send us information about, your problem.

Grievances

A grievance can be filed with us over the phone or in writing. You need to file your grievance within 60 calendar days from the date the problem took place.

If you have questions or concerns about your care, try to talk to your doctor first. Then if you still have questions or concerns, call us.

If you need help filing your grievance, one of our associates can help you. If you do not speak English, we can get an interpreter for you.

Part 6 – How to resolve a problem with Anthem

We care about the quality of care you get from us and your doctors. If you have a concern, call us at Member Services at 1-866-408-6131 (TTY 711), Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

Here are some things we can help you with:

- Finding a doctor
- Finding care and treatment
- Issues about how we run the health plan
- Any aspect of your care

You will not be treated differently because you call us with a problem or complaint.

What if my problem has to do with a denial of my benefits?

You need to file an appeal instead of a grievance. Learn how to Make an appeal. The information is located in this section.
You have three ways to file a grievance with us

1. **Call Member Services** at 1-866-408-6131 (TTY 711).
2. **Complete a grievance form** found on www.anthem.com/inmedicaid.
3. **Write us a letter** to tell us about the problem.

These are the things you need to tell us as clearly as you can:
- Who is involved in the grievance
- What happened
- When did it happen
- Where did it happen
- Why you’re not happy

Send your completed form or letter, along with any documents, to:

**Grievance Coordinator**
Anthem Blue Cross and Blue Shield, P.O. Box 62429, Virginia Beach, VA 23466

If we can’t make a decision about your grievance within 30 calendar days, we can ask the state agency to give us extra time (up to 14 calendar days). If we do this, we’ll send you a letter to tell you why we need more time.

**Expedited (rush) grievance**

Members must request an expedited grievance by fax only. Please fax to 1-855-516-1083.

If you think waiting 30 calendar days may harm your health, we may be able to give you an answer within 48 hours. This is called an expedited (faster) grievance. In your request, tell us why you think waiting 30 calendar days would harm your health. We’ll make a decision and try to call you within 48 hours from the time we get your grievance. We also will send you a letter within five business days after making our decision.

You also need to show facts proving your claim. This needs to be done within a certain time period. A medical director reviews requests for faster appeals. If the medical director thinks waiting 30 calendar days won’t harm your health, we’ll send you a letter within two business days to let you know we’ll complete your grievance as quickly as we can but within 30 calendar days. We’ll also try to call you to tell you our decision.

**Appeals**

If you want to file an appeal about how we solved your problem, an appeal can be requested within 60 calendar days from the day of our decision on the grievance resolution letter.

Send your appeal to:

**Appeals Department**
Anthem Blue Cross and Blue Shield, P.O. Box 62429, Virginia Beach, VA 23466

We’ll send you an acknowledgement letter within three business days after we get your appeal. The letter will tell you we got your appeal request.

You can also ask for an appeal by calling Member Services at 1-866-408-6131 (TTY 711). You must ask for an appeal in writing after you ask for one over the phone, unless you ask for a rush appeal.

We’ll make a decision about your appeal within 30 calendar days after we get it. If we cannot decide within 30 calendar days, we can ask the state agency to give us more time (up to 14 calendar days). If we do this, we’ll send you a letter to tell you why we need more time.

Once your appeal is resolved, we’ll send you a letter to tell you about the decision explaining:
- How to file an external independent review request.
- Ways to get a faster review.
- Your right to keep your benefits during the review.
- That you may have to pay for care you get while you wait for the decision.

**Expedited (rush) appeal**

Members must request an expedited appeal by fax only. Please fax to 1-855-516-1083.

You may ask us to rush your appeal if your health needs it. We’ll let you know we got your appeal within 24 hours from the time we received it. We send you a letter with our decision within 48 hours. If we say no to your request for a rush appeal, we’ll call and send you a letter with the reason for the delay within two calendar days.

You may keep your benefits while you’re waiting for your appeal if you asked for the appeal within the right time frame. You may have to pay for the care you get while you wait for an answer about the appeal if the final decision is not what you wanted.
External independent review

We have a special process called an external independent review (EIR). This process provides a neutral review of benefit decisions made by Anthem.

The EIR is used to resolve grievance appeals if we said no to paying for a service:
- You or your doctor asked for.
- That has to do with your medical needs.
- You asked for that has not been proven to work.

A written request must be filed for this process. This must be filed within 120 calendar days for Hoosier Care Connect or 33 calendar days for Healthy Indiana Plan and Hoosier Healthwise from the date we told you that your appeal had been denied. Within three business days after we get your request, we’ll send you a letter to say we got it.

EIRs are resolved within 15 business days from the date of request. We’ll send you a letter with the answer within 72 hours from when we decided. The letter will explain:
- Your right to ask for a Medicaid hearing.
- How to ask for a hearing.
- Your right to keep your benefits until the hearing is over.
- That you may have to pay the costs for services that you’re waiting for if the decision is not what you asked for at the start.

Expedited (rush) external independent review

You may ask us to rush your external independent review (EIR) if your health needs it. Members must request an expedited external independent review by fax only. Please fax to 1-855-516-1083.

We’ll take care of your request as fast as we can, but no more than 72 hours from the time we get your appeal. We’ll send you a letter within 24 hours after we make a decision.

Medicaid hearing and appeal process

If you have a problem with what we decide after completing our appeal process, you can ask for a Medicaid hearing and appeal review. You may ask for this review if we:
- Said no to paying for a service you wanted.
- Said OK to a service, but then we put limits on it.
- Ended payment for a service that we said OK to before.
- Did not give you access to a service fast enough.
- Did not confirm you were medically frail.

To ask for a review, you must send a letter to the state Medicaid agency within 120 calendar days of getting our decision about your appeal. Send your request to:

FSSA Hearings and Appeals
RM E034 — IGC-S, MS04, 402 W. Washington St., Indianapolis, IN 46204

Steps to take if you’re unhappy:

A judge will hear your case and send you a letter with the decision within 90 business days of the date that you first asked for a hearing.

If you have a problem with the judge’s decision, you can ask for an agency review. You must file for this review within 10 business days after you get your notice of the judge’s decision.

You’ll get a written notice of action from the agency review. If the hearing decision was reversed or changed, a letter will give the reasons.

If you’re not happy with what the agency decides, you may file for a judicial review.
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices

The original effective date of this notice was April 14, 2003. The most recent revision date is shown at the end of this notice.

Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you’re a member right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid and the Children’s Health Insurance Program after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs and hospitals so we can OK and pay for your health care.

Federal law says we must tell you what the law says we have to do to protect PHI that’s told to us, in writing or saved on a computer. We also have to tell you how we keep it safe.

To protect PHI:
- On paper (called physical), we:
  - Lock our offices and files
  - Destroy paper with health information so others can’t get it
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can get in
  - Use special programs to watch our systems
- Used or shared by people who work for us, doctors or the state, we:
  - Make rules for keeping information safe (called policies and procedures)
  - Teach people who work for us to follow the rules

When is it OK for us to use and share your PHI?

We can share your PHI with your family or a person you choose who helps with or pays for your health care if you tell us it’s OK. Sometimes, we can use and share it without your OK:

- For your medical care
  - To help doctors, hospitals and others get you the care you need
- For payment, health care operations and treatment
  - To share information with the doctors, clinics and others who bill us for your care
  - When we say we’ll pay for health care or services before you get them
  - To find ways to make our programs better, as well as giving your PHI to health information exchanges for payment, health care operations and treatment. If you don’t want this, please visit www.anthem.com/inmedicaid for more information.
- For health care business reasons
  - To help with audits, fraud and abuse prevention programs, planning, and everyday work
  - To find ways to make our programs better
- For public health reasons
  - To help public health officials keep people from getting sick or hurt
- With others who help with or pay for your care
  - With your family or a person you choose who helps with or pays for your health care, if you tell us it’s OK
  - With someone who helps with or pays for your health care, if you can’t speak for yourself and it’s best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We can’t take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

Other ways we can — or the law says we have to — use your PHI:

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we’re asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams
- To help coroners, medical examiners or funeral directors find out your name and cause of death
- To help when you’ve asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to workers’ compensation if you get sick or hurt at work
What are your rights?
• You can ask to look at your PHI and get a copy of it. We don’t have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
• You can ask us to change the medical record we have for you if you think something is wrong or missing.
• Sometimes, you can ask us not to share your PHI. But we don’t have to agree to your request.
• You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.
• You can ask us to tell you all the times over the past six years we’ve shared your PHI with someone else. This won’t list the times we’ve shared it because of health care, payment, everyday health care business or some other reasons we didn’t list here.
• You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
• If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What do we have to do?
• The law says we must keep your PHI private except as we’ve said in this notice.
• We must tell you what the law says we have to do about privacy.
• We must do what we say we’ll do in this notice.
• We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, like if you’re in danger.
• We must tell you if we have to share your PHI after you’ve asked us not to.
• If state laws say we have to do more than what we’ve said here, we’ll follow those laws.
• We have to let you know if we think your PHI has been breached.

Contacting you
We, along with our affiliates and/or vendors, may call or text you using an automatic telephone dialing system and/or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we won’t contact you in this way anymore. Or you may call 1-844-203-3796 to add your phone number to our Do Not Call list.

What if you have questions?
If you have questions about our privacy rules or want to use your rights, please call Member Services at 1-866-408-6131 (TTY 711).

What if you have a complaint?
We’re here to help. If you feel your PHI hasn’t been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

Write to or call the Department of Health and Human Services:
Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Phone: 1-800-368-1019
TDD: 1-800-537-7697
Fax: 1-312-886-1807

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we’ll tell you about the changes in a newsletter. We’ll also post them on the Web at www.anthem.com/inmedicaid.

Race, ethnicity and language
We receive race, ethnicity and language information about you from the state Medicaid agency and the Children’s Health Insurance Program. We protect this information as described in this notice. We use this information to:
• Make sure you get the care you need.
• Create programs to improve health outcomes.
• Develop and send health education information.
• Let doctors know about your language needs.
• Provide translator services.

We do **not** use this information to:
• Issue health insurance.
• Decide how much to charge for services.
• Determine benefits.
• Disclose to unapproved users.
Your personal information

We may ask for, use and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It’s often taken for insurance reasons.

- We may use your PI to make decisions about your:
  - Health
  - Habits
  - Hobbies
- We may get PI about you from other people or groups like:
  - Doctors
  - Hospitals
  - Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
  - We’ll let you know before we do anything where we have to give you a chance to say no.
  - We’ll tell you how to let us know if you don’t want us to use or share your PI.
  - You have the right to see and change your PI.
- We make sure your PI is kept safe.

Anthem Blue Cross and Blue Shield follows federal civil rights laws. We don’t discriminate against people because of their:

- Race
- Color
- National origin
- Age
- Disability
- Sex or gender identity

That means we won’t exclude you or treat you differently because of these things.

Communicating with you is important

For people with disabilities or who speak a language other than English, we offer these services at no cost to you:

- Qualified sign language interpreters
- Written materials in large print, audio, electronic and other formats
- Help from qualified interpreters in the language you speak
- Written materials in the language you speak

To get these services, call the Member Services number on your ID card. Or you can call our Grievance Coordinator at 1-866-408-6131 (TTY 711).

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc., independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
Do you need help with your health care, talking with us or reading what we send you? We provide our materials in other languages and formats at no cost to you. Call us toll free at 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

¿Necesita ayuda para con su cuidado de la salud, para hablar con nosotros o leer lo que le enviamos? Proporcionamos nuestros materiales en otros idiomas y formatos sin coste alguno para usted. Llámenos a la línea gratuita al 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

هل تحتاج إلى مساعدة فيما يتعلق برعاية الصحة أو في النصوص النادرة أو صياغة ما نرسله؟ نوفر المواد الخاصة باللغات وتسميات أخرى مجانًا، انطلق باللغة العربية: 1-844-284-1797 (Hoosier Healthwise, Healthy Indiana Plan); TTY 711 (Hoosier Care Connect).

Avez-vous besoin d’aide pour vos soins de santé, pour parler avec nous ou pour lire ce que nous envoyons? Nous vous offrons notre matériel dans d’autres langues et formats, sans frais pour vous. Appelez-nous sans frais à 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

Brauchen Sie etwas Hilfestellung mit Ihrer Gesundheitsfürsorge, wenn Sie mit uns reden oder lesen, was wir Ihnen senden? Wir stellen unsere Materialien kostenfrei in anderen Sprachen und Formaten bereit. Rufen Sie uns gebührenfrei unter den folgenden Rufnummern an: 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

¿Necesita ayuda para con su cuidado de la salud, para hablar con nosotros o leer lo que le enviamos? Proporcionamos nuestros materiales en otros idiomas y formatos sin coste alguno para usted. Llámenos a la línea gratuita al 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

Brauchen Sie etwas Hilfestellung mit Ihrer Gesundheitsfürsorge, wenn Sie mit uns reden oder lesen, was wir Ihnen senden? Wir stellen unsere Materialien kostenfrei in anderen Sprachen und Formaten bereit. Rufen Sie uns gebührenfrei unter den folgenden Rufnummern an: 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

Brauchen Sie etwas Hilfestellung mit Ihrer Gesundheitsfürsorge, wenn Sie mit uns reden oder lesen, was wir Ihnen senden? Wir stellen unsere Materialien kostenfrei in anderen Sprachen und Formaten bereit. Rufen Sie uns gebührenfrei unter den folgenden Rufnummern an: 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.
Вы нуждаетесь в помощи при получении медицинского обслуживания, во время общения с нами или с прочтением того, что мы вам посылаем? Мы предоставляем бесплатно наши материалы на других языках и в иных форматах. Позвоните нам бесплатно по телефону 1-866-408-6131 (программа Hoosier Healthwise, программа Healthy Indiana Plan); 1-844-284-1797 (программа Hoosier Care Connect); TTY 711.

Kailangan mo ba ng tulong sa iyong pangangalagang pangkalusugan, pakikipag-usap sa amin o pagbasa sa ipinapadala namin sa iyo? Ibinibigay ang aming mga materyal sa ibang mga wika at format nang wala kang babayaran. Tawagan kami nang libre sa 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

Quy vi có cần giúp đỡ về dịch vụ chăm sóc sức khỏe của quý vị thông qua việc trao đổi với chúng tôi hoặc đọc những tài liệu mà chúng tôi gửi cho quý vị hay không? Chúng tôi cung cấp cho quý vị các tài liệu bằng các ngôn ngữ và định dạng khác miễn phí. Hãy gọi chúng tôi theo số điện thoại miễn cước 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.