HIP HEALTHY INDIANA PLAN

Anthem

Healthy Indiana Plan
Member Handbook

Serving Hoosier Healthwise,
Healthy Indiana Plan
and Hoosier Care Connect

1022394INMENABS 10/22

MEMBER HANDBOOK
Anthem Blue Cross and Blue Shield

To get this handbook in other formats, such as Braille, large print or audio CD, call our Member Services at **866-408-6131 (TTY 711)** Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

You can learn more about Anthem on our website at **anthem.com/inmedicaid**.

Welcome and thank you for joining Anthem Blue Cross and Blue Shield!

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)** healthcare 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's 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 healthcare services. If you're a HIP Plus Plan member, pay your contribution on time every month. Thank you again for choosing us as your healthcare plan!

Sincerely,

Kimberly Roop, MD
Plan President

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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.

TTY lines are only for members with hearing or speech loss.

Important phone numbers

Service	Phone number	Information
∘ Member Services	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 helpline	866-408-6131 (TTY 711)	Talk in private with a nurse 24 hours a day, seven days a week. You may also call this line for an interpreter.
∘ Behavioral Health Crisis Hotline	833-874-0016 (TTY 711)	Call the Behavioral Health Crisis Hotline and speak to a licensed behavioral health professional. You can call 24 hours a day, 7 days a week. We are here to help you when you are going through a mental health or substance use crisis. We want to make sure you get the right services as soon as possible.
∘ Utilization Management (UM)	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	844-772-6632 (TTY 888-238-9816)	Set up nonemergency transportation to doctor appointments at least two business days before your appointment. Calls for routine reservations are accepted Monday through Friday from 8 a.m. to 8 p.m. Eastern time. Calls for urgent and same-day reservations are accepted 24/7. Calls for cancellations, status updates, and hospital discharges are accepted 24/7.
∘ National Poison Control Center (Calls are routed to the closest local office.)	800-222-1222	Talk with a nurse or doctor for free poison prevention advice and treatment 24 hours a day, seven days a week.

Service	Phone number	Information
◦ Relay Indiana	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.
◦ Superior Vision	866-866-5641 (TTY 800-428-4833)	Find an eye doctor in your plan or learn more about your vision benefits.
◦ Women, Infants, and Children (WIC)	800-522-0874	Learn more about this program, which gives healthy food to pregnant members and young mothers.
◦ Indiana Family and Social Services Administration (FSSA)	800-403-0864	Call this number to report any information changes like phone, address, and income.
◦ FSSA Prior Claims Payment program	800-457-4584	Speak with a program administrator about the prior claims payment program.
◦ HIP Enrollment broker	877-438-4479	Can help answer questions in changing plans or update member status.
◦ Indiana Tobacco Quitline	800-784-8669	Free phone service to help smokers quit.
◦ DentaQuest	888-291-3762	Find a dentist or learn more about your dental services.
◦ Translation or format services	866-408-6131 (TTY 711)	We can translate this handbook in other languages or forms such as Braille, large print or audio CD. We can translate this free of charge.

TTY lines are only for members with hearing or speech loss.

Technology at your service

Anthem offers online tools to make it easier for you to access care and services. With our secure member website and mobile app, you can manage your healthcare with a few clicks. Just go to our website at 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.
- See your care plan.
- 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:

Program	Web address	Details
◦ Healthy Rewards	anthem.com/AnthemRewards	Offers many rewards for staying healthy.
◦ Blue Ticket to Health	anthem.com/blueticket	We teamed up with the Indianapolis Colts so you can win prizes for getting your wellness checkup.
◦ HIP Plus	chooseanthem.com/in	HIP Plus offers the best value with extra benefits and no copays.
◦ Anthem Third-Party Payment Center	anthem.com/Pay4HIP	For employers and groups, like churches and foundations, who would 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.**

Yes, we have an app for that, too.

The Sydney Health mobile app puts your healthcare at your fingertips.
Download is free on the App Store® and Google Play™. You can use the app to:

- Check your POWER Account.
- Find a doctor, hospital or pharmacy in your plan.
- View your claims.
- See your care plan.
- Check your symptoms.
- Talk with a nurse 24/7 about your health.

Anthem Concierge Unit

Managing healthcare can be hard. That's why we created the Anthem Concierge Unit.
This service can help you:

- Complete your Health Needs Screening (HNS).
- Schedule appointments with your primary medical provider (PMP).
- Connect to community services like Women, Infants, and Children (WIC).

Call 866-408-6131 (TTY 711) for the Concierge Unit today.

You can also write the Anthem Concierge Unit at:

Anthem Blue Cross and Blue Shield
Mailstop IN0205 C442
220 Virginia Ave.
Indianapolis, IN 46209-6227

Has your phone number or address changed?

Let Indiana Family and Social Services Administration (FSSA) know right away. They'll update their records and send the changes to us. To update your phone or address, you can:

- Go to fssabenefits.in.gov. At the top right-hand corner, select either **Sign In** or **Create Account**. Once logged in, select **Manage**, and then **Update Your Contact Information**.

Call Member Services at 866-408-6131 (TTY 711) and report the change to Anthem.

HIP Benefits and Copay Comparison Guide

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

*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:

Enhanced benefits	Details
Smartphone Member Connect	Limited to one per household: • Free monthly minutes • 4GB data and text messaging • One-time bonus of 200 minutes • 100 minutes in birthday month
Essentials for Expectant Moms	• New parent product toolkit • Online learning courses on pregnancy, postnatal care, and new baby care • Essential items to keep baby safe
Healthy Adults Healthy Results	• Online fitness program and resources • Gym membership for up to six months • WW® membership for up to 13 weeks
Healthy Meals	• 10 frozen healthy family meals delivered to your home • **HIP Plus members only**
Fresh Fruits and Veggies Program	• One produce box per month for three months delivered to your home • For pregnant or nursing moms six weeks postpartum
Post-discharge meals	• Two customized meals per day for seven days (up to 14 meals) delivered to your home • **HIP Plus members only**
Personal care essentials	• Up to $50 per member per year for over-the-counter products • **HIP Plus members only**
Jump Start Program	• Access to online learning platform that includes job skills training, 1-on-1 coaching, test preparation, job search tool, and more • **HIP Plus members only**
High School Equivalency (HSE) Assistance	• Voucher to cover the cost of HSE tests, practice test, and up to two retests • **HIP Plus members only**
Asthma and COPD relief toolkit	• Up to $80 in asthma and allergy relief products • **HIP Plus members only**
Non-pharmacologic pain management	• Up to $50 for products to help with managing pain • **HIP Plus members only**

Enhanced benefits	Details
Community Resource Link	Online tool to help you find community-based resources in your area that support health and well-being
Transportation essentials	To assist members in accessing community services and supports, and employment opportunities, eligible HIP State Plan Plus, HIP Regular Plan Plus and HIP Maternity Plan members may choose one of the following: • $50 gas card • $50 rideshare gift card • Up to $50 in bus passes

Some of these enhanced benefits are limited to certain members and may require completing a health screening, annual dental or wellness visit, registration on our secure member portal, or other qualifications. To find out which benefits you may qualify for, visit the Benefit Reward Hub or call Member Services at 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, 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 find the right healthcare for you. To take the HNS, you can also visit **anthem.com/hns** or call **866-408-6131 (TTY 711)**.

Ways to good 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 healthcare needs.
- ✔ **Take the Health Needs Screening** — It helps us get the right care for you. You can earn up to $30! See the *Healthy Rewards Program* section for details.
- ✔ **Schedule a health checkup** — Call your PMP to make an appointment within 60 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 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 healthcare costs you might have.
- ✔ **Keep your member ID card close** — Show it every time you need healthcare services.

Pharmacy services

You can get prescriptions filled at any pharmacy in your plan, including:

- Prescription drugs.
- Over-the-counter (OTC) items approved by the Food and Drug Administration (FDA) 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.

Healthy Rewards for getting and staying healthy

At Anthem, we want you to be as healthy as you can be. Great health starts with preventive care. Preventive care may include any needed exams, screenings, or vaccinations. It's the care you get when you're not sick so your doctor can help you before you get sick. Your health is so important, we want to reward you for taking care of it.

There are many types of care you can get to earn incentives through our Healthy Rewards program. Talk with your doctor about preventive care that's right for you. We'll send you texts and emails to let you know which incentives apply to you.

The first reward is for completing the Health Needs Screening (HNS) within 90 days of joining. You can complete the HNS and earn your rewards:

- Online at anthem.com/hns.
- By calling 866-408-6131 (TTY 711).

New Anthem members will receive more details about completing the HNS and other healthy activities. Go to anthem.com/AnthemRewards to find out what other rewards you may be able to earn.

Healthy Rewards program rules

- Medicaid must be your primary insurance.
- You must be an eligible Anthem member at the time the reward is used. If there is a lapse in your coverage after earning the reward, you will not be eligible to use the reward.
- Your Healthy Rewards may only be used at participating retailers like Amazon, DoorDash, Marshall's, and TJ Maxx in Indiana.
- The purchase of alcohol, tobacco, e-cigarettes, firearms, or prescription drugs is not allowed.
- You must have a valid email address.

How to start earning Healthy Rewards

Register by logging in to the Benefit Reward Hub to redeem your Healthy Rewards and view the rewards you are eligible for. You can also access your Healthy Rewards through the "My Health Dashboard" section of Sydney Health, our mobile app. Or, call the Rewards customer service line at 888-990-8681 (TTY 711).

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

Blue Ticket to Health

Anthem has teamed up with the Indianapolis Colts to help members ages 3 and up stay 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 prizes including Colts merchandise. Go to 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 by visiting 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 24/7 NurseLine at 866-408-6131 (TTY 711).

Urgent care symptoms:

- Cold, flu, or sore throat
- Earache
- Vomiting or diarrhea
- Common sprain
- Minor broken bone
- Minor cuts
- Mild asthma/allergic reactions
- Rash without fever

ER symptoms:

- Chest pain or difficulty breathing
- Head and eye injuries
- Uncontrolled bleeding or severe cuts
- Bad broken bone, such as a bone that has broken through skin
- Coughing or vomiting blood
- Bleeding during pregnancy
- Baby under 8 weeks with fever
- Rash with fever

If you go to the ER and it's not an emergency, you may be charged an $8 copay. But if you call 24/7 NurseLine first, and they tell you to go to the ER, that $8 copay will be waived. Call 24/7 NurseLine at 866-408-6131 (TTY 711) for assistance.

Your primary medical provider

Your primary medical provider (PMP) is the first person you should call for your healthcare needs. Your PMP coordinates things like:

- Checkups and vaccines.
- Referrals to specialists.
- Referrals for tests and services.
- Admission to a hospital.

Easy ways to pay your HIP Plus POWER Account

Bank draft	Have payments taken from your account.
Online	Register at anthem.com/inmedicaid. Or pay online through your bank.
Telephone	Call Member Services at 866-408-6131 (TTY 711). Allow five days to post to your account.
MoneyGram	To make a cash payment, just go to any MoneyGram location.
Mail	Anthem Blue Cross and Blue Shield P.O. Box 6431 Carol Stream, IL 60197-6431
Contributions	From your employer or a non-profit group.

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

Keep your healthcare during redetermination

When you first enroll in HIP, you may be eligible for up to 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.

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 the state doesn't have enough information, they'll ask you for more information.
- You must complete and return the requested information to stay enrolled in HIP.
- 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.

Also, you can choose your health plan each year between November 1 and December 15, during the Health Plan Selection Period.

What is a POWER Account?

The first $2,500 of your approved healthcare 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!

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 877-438-4479 or visit in.gov/fssa to learn more about disability or other assistance programs that may meet your needs.

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.

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 include vision or dental services, except for members who are 19 or 20 years of age and pregnant members.
- Does not include chiropractic services.
- You're limited to a 30-day supply of medications and cannot have mail orders.
- Does not include medication therapy management services.

HIP State Plan benefits

HIP State plan benefits include some extra benefits for members who are:

- Low-income parents and caretakers, 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 healthcare 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 one or more of the following conditions:

- 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 866-408-6131 (TTY 711). If you qualify as medically frail, you may have to pay monthly contributions and pay copays if your income is over 100% of the Federal Poverty Level and you fail to make timely payments to your POWER Account.

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.
- You have no POWER Account payments during the pregnancy.
- Your POWER Account is frozen while you are in the Maternity plan, so no medical expenses are deducted from your POWER Account.
- During your pregnancy, you get all the great benefits you were receiving under your regular HIP plan like doctor, hospital, and lab services, plus added benefits including vision, dental, and chiropractic services as well as rides to doctor appointments.

At the end of your pregnancy, you'll receive 12 months of postpartum benefits. Following that period, you will move to the HIP Basic plan and be given an opportunity to make a POWER Account payment to move to HIP Plus.

Pregnancy and Postpartum care

As soon as you know you're pregnant:

- Call Member Services toll free at 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. At your first prenatal care visit, your doctor should schedule additional visits throughout your pregnancy to keep you and your baby healthy. Seeing your doctor regularly during your pregnancy is important.
- When you become pregnant, you will move to the HIP Maternity plan. You will remain in this plan for 12 months after the end of your pregnancy.
- Know that while pregnant, you won't have to make payments to your POWER Account or have copays for healthcare services.
- If you need behavioral healthcare, you can go to any Indiana Health Coverage Programs (IHCP) doctor.

New Baby, New Life℠

It is very important to see your primary medical provider (PMP) or obstetrician or gynecologist (OB-GYN) for care when you are pregnant. This kind of care is called prenatal care. It can help you to have a healthy baby. Prenatal care is important each time you are pregnant. With our program, you'll have access to health information and may receive incentives for going to your appointments.

Our program also helps pregnant individuals with complicated healthcare needs. Nurse care managers work closely with these individuals to provide:

- Education.
- Emotional support.
- Help in following their doctor's care plan.
- Information on services and resources in your community.

Our nurses also work with doctors and help with other services you may need. The goal is to promote better health for individuals and delivery of healthy babies.

Quality care for you and your baby

At Anthem, we want to give you the very best care during your pregnancy. That's why you will also be part of My Advocate®, which is part of our New Baby, New Life℠ program. My Advocate gives you the information and support you need to stay healthy during your pregnancy.

Get to know My Advocate®

My Advocate delivers maternal health education by phone, web, and smartphone app that is helpful and fun. If you choose the phone version, you will get to know Mary Beth, My Advocate's automated personality. Mary Beth will respond to your changing needs as your baby grows and develops. You can count on:

- Education you can use.
- Communication with your care manager based on My Advocate messaging should questions or issues arise.
- An easy communication schedule.
- No cost to you.

With My Advocate, your information is kept secure and private. Each time Mary Beth calls, she'll ask you for your year of birth. Please don't hesitate to tell her. She needs the information to be sure she's talking to the right person.

Helping you and your baby stay healthy

My Advocate® calls give you answers to your questions, plus medical support if you need it. There will be one important health screening contact followed by ongoing educational outreach. All you need to do is listen, learn, and answer a question or two. If you tell us you have a problem, you'll get a call back from a care manager. My Advocate topics include:

- Pregnancy care.
- Postpartum care.
- Well-child care.

When you become pregnant

If you think you are pregnant:

- Call your PMP or OB-GYN doctor right away. You do not need a referral from your PMP to see an OB-GYN doctor.
- Call Member Services at 866-408-6131 (TTY 711) if you need help finding an OB-GYN in the Anthem network.

When you find out you are pregnant, you must also call Member Services at 866-408-6131 (TTY 711). You should also report your pregnancy to Indiana Family and Social Services Administration (FSSA) at 800-403-0864.

Visit our Pregnancy & Women's Health page at anthem.com/inmedicaid under Health & Wellness Resources for information and resources on how to keep you and your baby healthy. If you would like to receive pregnancy information by mail, please call Member Services at the number on your member ID card.

You can access education, including:

- Self-care information about your pregnancy.
- Details on My Advocate® that tells you about the program and how to enroll and get health information to your phone by automated voice, web, or smartphone app.
- Healthy Rewards program information on how to redeem your incentives for prenatal, postpartum, and well-baby care.
- Education on having a healthy baby, postpartum depression, and caring for your newborn, with helpful resources.

While you are pregnant, you need to take good care of your health. You may be able to get healthy food from the Women, Infants, and Children (WIC) program. Member Services can give you the phone number for the WIC program close to you.

When you are pregnant, you must go to your PMP or OB-GYN at least:

- Every four weeks for the first six months.
- Every two weeks for the seventh and eighth months.
- Every week during the last month.

Your PMP or OB-GYN may want you to visit more than this based on your health needs.

When you have a new baby

When you deliver your baby, you and your baby may stay in the hospital at least:

- 48 hours after a vaginal delivery.
- 72 hours after a Cesarean section (C-section).

You may stay in the hospital less time if your PMP or OB-GYN and the baby's provider see that you and your baby are doing well. If you and your baby leave the hospital early, your PMP or OB-GYN may ask you to have an office or in-home nurse visit within 48 hours.

After you have your baby

- You must call Anthem Member Services at 866-408-6131 (TTY 711) as soon as you can. We will need some information.
- You must call the Indiana Family and Social Services Administration at 800-403-0864 to report the birth.

After your baby is born, the My Advocate® program will switch from prenatal education to postpartum and well-child education for up to 12 weeks after your delivery.

It's important to set up a visit with your PMP or OB-GYN after you have your baby for a postpartum checkup. You may feel well and think you are healing, but it takes the body at least six weeks to mend after delivery.

- The visit should be done between 7 to 84 days after you deliver.
- If you delivered by C-section or had complications with your pregnancy or delivery, your PMP or OB-GYN may ask you to come back for a one- or two-week checkup. This is not considered a postpartum checkup. You will still need to go back and see your provider within 7 to 84 days after your delivery for your postpartum checkup.

It's also important to schedule a well-baby visit for baby. Your baby's PMP can provide the best care by working closely with you. For the first years of life, the American Academy of Pediatricians suggest that your baby have a checkup at birth, 3 to 5 days old, and at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months. At these visits, your baby's doctor will make sure your baby is getting all the care baby needs including well checks, vaccines, and other care suggested by the Bright Futures EPSDT coverage recommendations.

Prenatal rewards

If you're pregnant, you could be rewarded for getting the needed prenatal and postpartum care for you and your baby. To learn more, visit anthem.com/AnthemRewards or call Member Services toll free at 866-408-6131 (TTY 711) to receive information on our prenatal rewards.

CenteringPregnancy®

CenteringPregnancy is a peer support group, offering individuals 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 individuals about their babies. Participants 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 individuals. 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 babyandmetobaccofree.org to find out more.

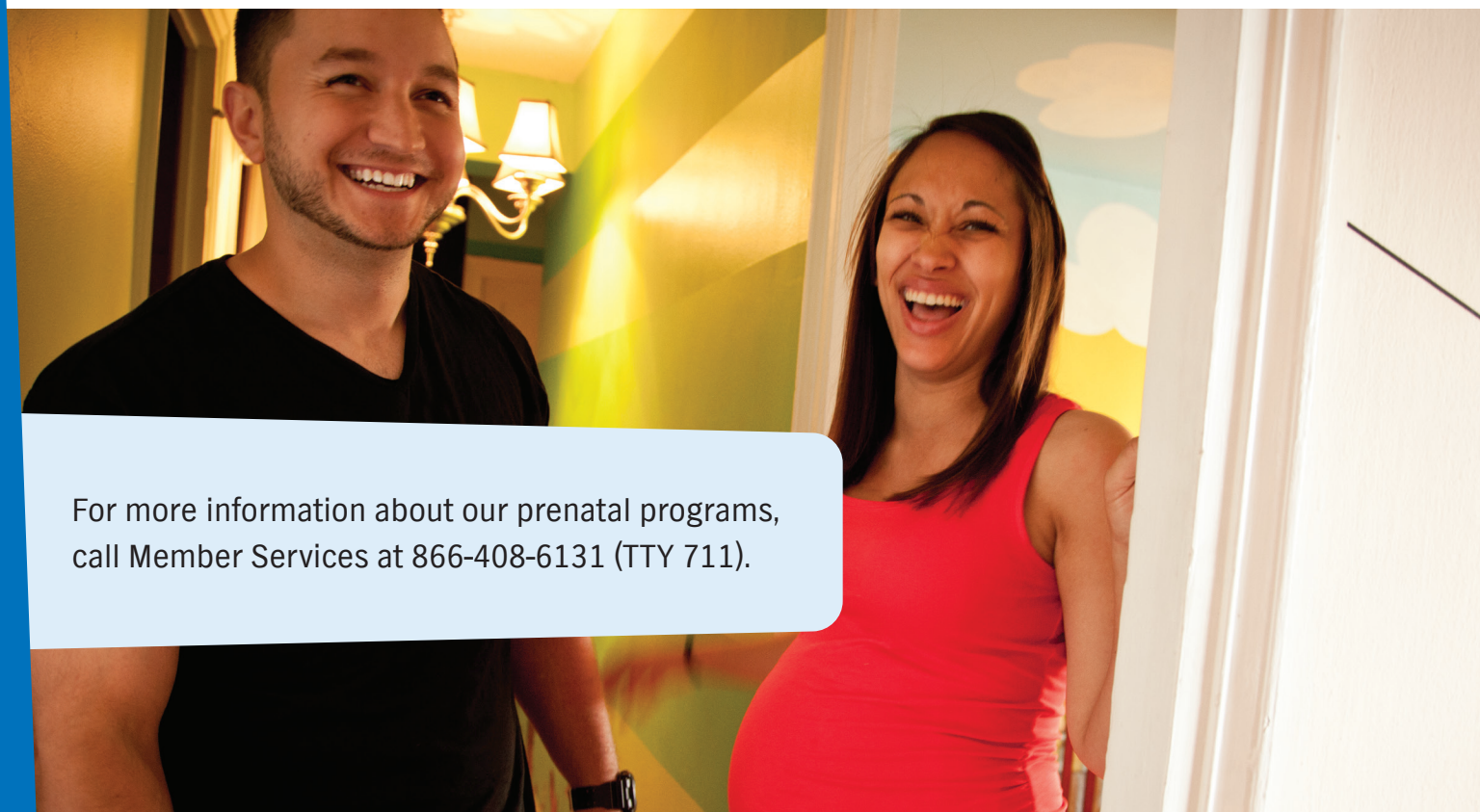
Copays in the HIP program

A copay is the amount you pay each time you go to the doctor or get prescriptions. In HIP, members who are Native American/Alaska Native, pregnant or who have hit the 5% cost-sharing limit do not have copays. There are no copays for preventive care services.

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 24/7 NurseLine at 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.



For more information about our prenatal programs, call Member Services at 866-408-6131 (TTY 711).

Need a ride?

Anthem Transportation Services can help you find out what transportation options are available in your area. You may be able to use public transportation, have a pickup and drop-off service, or be eligible for mileage reimbursement.* For questions about each HIP Plan's transportation benefits, call Anthem Transportation Services at 844-772-6632 (TTY 888-238-9816) Monday through Friday, 8 a.m. to 8 p.m. Eastern time. You need to call at least two business days before your appointments — but you can call as many as 45 days in advance.

Riders must follow state and local laws. This includes wearing seat belts and ensuring minor children are properly secured. Adults are responsible for providing the child's safety seat.

**Not all HIP Plan members are eligible for transportation benefits. Find your HIP Plan below for more information.*

Indiana Quitline

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

HIP Basic and HIP Plus

The services listed below are for members in either HIP Basic or HIP Plus. A copay is the amount you pay each time you go to the doctor or get a prescription. In HIP, members who are Native American/Alaska Native, pregnant or who have hit the 5% cost-sharing limit do not have copays. Copays also do not apply to HIP Plus members, except for use of the emergency room when it's not an emergency.

Benefits	Details	Copay
◦ Doctor care	Includes: ◦ Preventive care ◦ Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program services, including routine dental visits, wellness visits and lead screening ◦ Physical exams ◦ Immunizations ◦ Specialty care	Basic: $4 for visits to the doctor and specialists. No copay for preventive care, including wellness exams, screenings and shots.
◦ Emergency room		Basic and Plus: $8 for ER use if it is not an emergency.
◦ Hospital	Inpatient services	Basic: $75
	Outpatient services and surgeries ◦ Bariatric (weight-loss) surgery is covered under HIP Plus	Basic: $4
◦ 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	No copay
◦ Post-stabilization services	Care provided in the ER or hospital after your condition is stable or improved, but before you leave the ER or hospital.	No copay
◦ Ambulance transportation for emergencies	Ride service to the emergency room (ER)	No copay
◦ Medical supplies	Includes: ◦ Durable medical equipment ◦ Hearing aids ◦ Orthotics and prosthetic devices	Basic: $4

Benefits	Details	Copay
• Physical, speech, occupational, respiratory, cardiac therapy	Basic: Up to 60 treatments for each episode per benefit period Plus: Up to 75 treatments per benefit period	Basic: $4
• Behavioral health	Care for mental health/substance abuse	Basic: $4
• Prescription services	Provided by Anthem Includes: • Prescription drugs • OTC drugs with a prescription • Diabetic supplies • Specialty drugs (some high-cost drugs are paid for by FSSA/OptumRx)	Members enrolled in HIP Basic pay: • $8 copay for nonpreferred • $4 copay for preferred prescriptions There are no pharmacy copays for HIP Plus.
• Smoking cessation	Includes: • Prescription and over-the-counter treatment, such as nicotine patches or gum • Counseling services • See the *Healthy Rewards* section to see how you can earn rewards by quitting smoking	No copay
• Renal dialysis	Coverage provided for home dialysis services.	Basic: $4
• Home healthcare	• Services include but not limited to nursing care given or supervised by RN and nutritional counseling. • 100 visits per year.	Basic: $4
• Skilled nursing facility	Up to 100 days	Basic: $75
• Hospice care	Provided in a facility or in the home for terminal illness, as part of a treatment plan before starting the program.	No copay
• Temporomandibular joint disorder (jaw disorder)	Offered under HIP Plus	No copay
• Nurse practitioner services	A nurse practitioner is a nurse who works with a primary medical provider (PMP).	Basic: $4

Benefits	Details	Copay
◦ Nonemergency transportation	Not a covered benefit. Eligible HIP Plus members receive limited transportation support as an enhanced benefit – see Enhanced Benefits section above.	No copay
◦ Dental	See Dental Benefits Summary below.	No copay
◦ Vision	◦ Approved for all Plus members and Basic members ages 19 and 20 ◦ Exams — One eye exam per year for members under 21 years old. — One eye exam every two years for members 21 years and older. ◦ Eyeglasses — One pair of eyeglasses per year for members under 21 years old, unless medically necessary under EPSDT. — One pair of eyeglasses every 5 years for members 21 years and older.	No copay

What is post-stabilization?

This is the care you get in the ER or hospital after your condition is stable, but before you leave the ER or hospital.

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 State Plan Plus and HIP Maternity members.

Benefits	Details	Copay
∘ Doctor care	Includes: ∘ Preventive care ∘ Physical exams ∘ Prenatal care ∘ Well-child checkups ∘ Immunizations ∘ Specialty care	State Basic: $4 for visits to the doctor and specialists. No copay for preventive care, including wellness exams, screenings and shots.
∘ Chiropractic services	Up to five visits per year and 50 therapeutic physical medicine treatments per year. Chiropractors are allowed to perform therapy services if licensed.	State Basic: $4
∘ Emergency room		State Basic and Plus: $8 for ER use if it is not an emergency.
∘ Hospital	Inpatient services	State Basic: $75
	Outpatient services and surgeries	State Basic: $4
∘ Lab tests and X-rays		State Basic: $4
∘ Post-stabilization services	Care provided in the ER or hospital after your condition is stable or improved, but before you leave the ER or hospital.	No copay
∘ Ambulance transportation for emergencies	Ride service to the emergency room (ER)	No copay
∘ Medical supplies	Includes: ∘ Durable medical equipment ∘ Hearing aids ∘ Orthopedic shoes and leg braces ∘ Orthotics and prosthetic devices	State Basic: $4
∘ Therapy services	Physical, speech, occupational and respiratory therapy	State Basic: $4
∘ Behavioral health	Care for mental health/substance abuse	State Basic: $4

Benefits	Details	Copay
• Prescription services	Provided by CarelonRx. Includes: • Prescription drugs. • OTC drugs with a prescription. • Diabetic supplies. • Specialty drugs (some high-cost drugs are paid for by FSSA/ OptumRx).	Members enrolled in HIP State Plan Basic pay: • $8 copay for nonpreferred. • $4 for preferred prescriptions. There are no pharmacy copays for HIP State Plan Plus.
• Smoking cessation	Includes: • One 12-week course of treatment per calendar year. • Prescription and OTC medicines, such as nicotine patches or gum. • Counseling services.	No copay
• Skilled nursing facility	• HIP Maternity - Up to 60 days per rolling 12-month period • State Basic and Plus - Up to 100 days per rolling 12-month period	State Basic: $75
• Hospice care	• Provided in a facility or in the home for terminal illness, as part of a treatment plan before starting the program.	No copay
• Renal dialysis	• Coverage provided for home dialysis services.	State Basic: $4
• Vision services	Exams • One eye exam per year for members under 21 years old. • One eye exam every two years for members 21 years and older. Eyeglasses • One pair of eyeglasses per year for members under 21 years old, unless medically necessary under EPSDT. • One pair of eyeglasses every five years for members 21 years and older.	State Basic: $4
• Dental	See Dental Benefits Summary below.	No copay
• Podiatry services	One office visit per year for HIP State Plan members only.	State Basic: $4
• Home healthcare	• Services include but not limited to nursing care given or supervised by RN and nutritional counseling. • 100 visits per year.	State Basic: $4

Benefits	Details	Copay
◦ Nurse practitioner services	A nurse practitioner is a nurse who works with a primary medical provider (PMP).	State Basic: $4
◦ Nonemergency transportation	◦ Unlimited trips to Medicaid providers. ◦ A trip is defined as door-to-door service, mileage reimbursement for member or driver, or bus passes. ◦ Additional transportation benefits are available – see Enhanced Benefits section above.	No copay

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 treatment
- 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
- Vitamins, supplements and over-the-counter (OTC) medicines not covered through the pharmacy benefit
- Private duty nursing
- For any condition, disease, defect, ailment or injury that takes place while working if you have workers' compensation
- The evaluation or treatment of learning disabilities

Services from doctors who are not in your plan

We contract with doctors to provide the care covered by your plan. Call your PMP or Member Services to find out if you need preapproval before seeing a doctor who isn't in your plan. You can also call us or visit our portal to find a doctor in your plan. You may be able to see this out-of-plan doctor for a self-referral service. See *Self-referral services* below for more details. Anthem does not pay for costs from out-of-plan doctors in most cases. We can only give preapproval for those who are part of the Indiana Health Care Programs (IHCP), which means they're part of the state's plan.

There are a few other situations in addition to self-referral care where we will pay for out-of-plan services. These situations include:

- Services for which you had preapproval from your previous health insurer. We will honor those preapprovals (sometimes called authorizations) for at least 90 days after you join our plan.
- If you are pregnant and join our health plan in your third trimester, we will allow you to continue to see your existing providers regardless of their contract status.
- If your PMP leaves our plan, you may continue to see them while we work with you to find a new PMP within our plan.

In the unlikely event where we have not contracted with a provider who offers the services you need within 60 miles of your home, we will work with you to find a provider, even if that provider is out-of-plan.

If you get a service from a doctor who is not in our plan or the service is not approved, it will be considered an out-of-plan service. This doesn't apply to some self-referral services.

Self-referral services

You can receive self-referral services from any IHCP provider, even if they aren't contracted with Anthem with the exception of certain behavioral health services.

Self-referral services include:

- Chiropractic care*
- Routine dental services**
- Diabetes self-care training
- Emergency services
- Eye and vision care (except surgical services)**
- Family planning
- HIV/AIDS care management
- Immunizations
- Behavioral health/psychiatric services†
- Podiatry service •
- Urgent care

** Not covered for HIP Basic members*
*** In the HIP Basic plan, this is covered for members ages 19-20 only.*
† Behavioral health providers who aren't psychiatrists must be contracted with Anthem.
• This is covered for HIP State Plan members only.

Other services

Indiana Health Coverage Programs (IHCP) covers some types of care for members. These types of services 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 services such as Behavioral and Primary Healthcare Coordination (BPHC) and Adult Mental Health and Habilitation (AMHH) services for members who may have special needs.

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

Dental benefit summary

Good dental health makes a big difference in your overall health. That's why it's important for you to keep your dental appointments and use your recommended dental benefits. 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.

Do you need help understanding your benefits, finding a dentist, or making an appointment? Please call DentaQuest at 888-291-3762 (TTY 711).

Benefit Level	Oral Examinations	Cleanings	X-rays
HIP Basic (ages 19-20)	2 exams per year	2 cleanings per year	1 complete set every 3 years 1 set of bitewing X-rays every year
HIP Basic (ages 21+)	No coverage	No coverage	No coverage
HIP Plus	2 exams per year	2 cleanings per year	1 complete set every 5 years 1 set of bitewing X-rays every year
HIP State Plan (ages 19-20) (State Plan Plus and State Plan Basic*)	2 exams per year	2 cleanings per year	1 complete set every 3 years 1 set of bitewing X-rays every year

Benefit Level	Oral Examinations	Cleanings	X-rays
HIP State Plan (ages 21+) (State Plan Plus and State Plan Basic*)	2 exams per year	1 cleaning per year	1 complete set every 3 years 1 set of bitewing X-rays every year
HIP Maternity (ages 19-20)	2 exams per year	2 cleanings per year	1 complete set every 3 years 1 set of bitewing X-rays every year
HIP Maternity (ages 21+)	2 exams per year	1 cleaning per year	1 complete set every 3 years 1 set of bitewing X-rays every year

* HIP State Plan Basic members have a $4 copay per type of dental service. For example, for fillings done on the same day, you will owe one $4 copay. There is no copay for preventive services like exams and cleanings. Members who are Native American/Alaska Native, pregnant or who have hit the 5% 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 healthcare 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 towards 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 every month.

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 after the first 12 months. 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 *Healthy Rewards* 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 877-GET-HIP-9 (877-438-4479) or
- Member Services at 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

Federal Poverty Level Tiers	Monthly PAC Member	Monthly PAC Spouse	Monthly PAC Member with tobacco surcharge	Monthly PAC - one tobacco surcharge	Monthly PAC - two tobacco surcharges
Up to 22%	$1.00	$1.00	$1.50	$1.00 & $1.50	$1.50
23%-50%	$5.00	$2.50	$7.50	$2.50 & $3.75	$3.75
51%-75%	$10.00	$5.00	$15.00	$5.00 & $7.50	$7.50
76%-100%	$15.00	$7.50	$22.50	$7.50 & $11.25	$11.25
101%-138%	$20.00	$10.00	$30.00	$10.00 & $15.00	$15.00

What happens if you don't pay on time?

If we don't receive your POWER Account contribution within 60 days of when it's due, these changes will happen:

- If you're considered to be medically frail, you'll be moved to HIP State Plan Basic. You'll have copays ranging from $4 to $75.
- If you are not medically frail, you may lose your coverage.

Five-percent cost-sharing limit

Each benefit quarter (or three months), you should not pay more than 5% 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% 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% of your family's income for the quarter on healthcare, call us immediately at Member Services at 866-408-6131 (TTY 711). You'll need to show written proof of the amount you paid.

If your income, household size, or contact information 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 or another type of insurance.
- Any other change that you think may affect your eligibility or benefits for HIP.

To make these updates:

- Go to FSSABenefits.in.gov
- Select Sign in or Create account and follow the prompts.
- Call Member Services at 866-408-6131 (TTY 711) if you need assistance.

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, sometimes called an ACH payment** — Have your payments automatically taken from your checking or savings account or even your credit card each month. To request a setup form, contact Member Services at 866-408-6131 (TTY 711) or you can also log in to anthem.com/inmedicaid and set up your automatic payments yourself.
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, sometimes called an electronic transfer** — Register at 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 to make a cash payment. You can find them at places like Walmart or CVS. A complete list is online at 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, debit card, or electronic check by calling Member Services at 866-408-6131 (TTY 711). 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. Employers and nonprofit groups can visit anthem.com/Pay4HIP to learn more. Your employer can also make your payments via an automatic payroll deduction. Your employer can call Member Services at 866-408-6131 (TTY 711) for more details.

What if I don't pay my POWER Account?

If your POWER Account is more than 60 days past due, you could lose some or all of your benefits. Keep your benefits by paying on time.

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.)*

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%.

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			
Annual physical	19+	**Cholesterol testing***	20+, every 5 years
Flu shot	19+	**Diabetes screen***	35+
Vision	19+	**Tetanus, diphtheria, pertussis (Tdap) vaccine***	20+, every 10 years
Dental	19+	**Colorectal cancer (CRC) screening***	45+, every 10 years
Mammogram*	40+	**Abdominal aortic aneurysm (AAA) screening**	65+ if ever a smoker, once
Pap smear*	21+, every 3 years	**Prostate cancer screening****	55+

* These are general guidelines and may change upon clinical recommendations from your primary medical provider (PMP).

** The decision to test for prostate cancer should be an individual one, and if done, future screening guidelines depend on the results of the initial test and clinical guidance from your primary medical provider (PMP).

Will I be charged for preventive services?

No. You get these benefits at no cost to you. Preventive care helps you improve your health, and it can help you manage your POWER Account and save money. By getting free preventive care and staying healthy, you may be able to:

- Use your POWER Account less.
- Qualify to have leftover funds roll over and reduce the following year's PAC.
- Save money on your healthcare.

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 anthem.com/inmedicaid or our mobile app 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.

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 anthem.com/inmedicaid and click on *Find a Doctor.*
- Call Member Services at **866-408-6131** (TTY **711**).

Your PMP is the first person you call for all your healthcare 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 healthcare 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.
- 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 our Member Services at 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 Coverage 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)
- Professional qualifications
- Specialty
- Medical school attended
- Residency completion
- Board certification status

Continuity of care

We're here to help new members get continuing care and coordination of medically necessary services when they join Anthem. This means we will help you if you are transitioning between plans, if you are pregnant, or you are receiving certain services, such as for HIV, Hepatitis C, and/or behavioral health. If you want to know if continuity of care is for you, call Member Services at 866-408-6131 (TTY 711).

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 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 within 60 days of joining Anthem. 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

If a child enrolled in Medicaid is at risk for lead exposure, a blood lead level (BLL) screening should be performed between the ages of 9 and 15 months, or as close as reasonably possible to the member's appointment. Children should have another blood test between the ages of 21 and 27 months, or as close as reasonably possible to the member's appointment. Any child between 28 and 72 months that does not have a record of any prior blood lead test must have a blood lead test performed as soon as possible. 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 daycare 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)?

If you checked one or more of the boxes above, please call Member Services at 866-408-6131 (TTY 711) to discuss taking a BLL test.

See the *Preventive Health Guidelines* on anthem.com/inmedicaid to learn more about wellness visits and shots.

Prepare for your doctor 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 healthcare.
2. **Show this ID card every time you need healthcare services.** Only you can get healthcare 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 anthem.com/inmedicaid. Or you can call 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 our 24/7 NurseLine at 866-408-6131 (TTY 711). 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 and you did not get 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 anthem.com/inmedicaid or on the mobile app. 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 selecting *Register now*. You'll need your member ID number located on your member ID card. We can also help you change your PMP over the phone by calling Member Services at 866-408-6131 (TTY 711).

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 866-408-6131 (TTY 711).

Receiving 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 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 healthcare at the right time in the right place. Your team will be made up of a PMP, a pharmacy, and a care manager. If you have questions about the Right Choices Program, call Member Services at 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 Member Services 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 (ABA).
- Medication services.
- Psychological testing.

Substance use disorder and opioid treatment services

Anthem covers substance use treatment to include residential treatment. Some services require prior authorization. We also provide full coverage for Opioid Treatment Program (OTP) services including all levels of care and methadone use and disease testing. Prior authorization is not required for OTP services. We contract with all Division of Mental Health and Addiction (DMHA) certified OTP providers across Indiana.

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 all adults

- Annual checkups and screenings such as Body Mass Index (BMI), blood pressure and diabetes
- Immunizations such as tetanus and the flu can keep you well
- Testing for sexually transmitted infections (STIs) such as HIV/AIDS

For women

- Services for women such as mammograms and cervical cancer screenings
- Pregnancy and childbirth classes to help you stay healthy while you're pregnant
- Family Services to help with a healthy pregnancy, preventing pregnancy, or preventing sexually transmitted infections (STIs) such as HIV/AIDS

For men

- Screenings in certain men for prostate cancer and abdominal aortic aneurysm

A 24/7 line for your peace of mind

24/7 NurseLine lets you talk in private with a registered nurse (RN) about your health. Teens can talk to RNs in private about teen issues. Just call 24/7 NurseLine at 866-408-6131 (TTY 711). You can also ask about audiotapes on 300 health topics.

You can find **Preventive Health Guidelines**, an information sheet with helpful ways to stay healthy, on our website at anthem.com/inmedicaid. We also offer information on specific health-related topics, the importance of preventive care, and how to navigate the healthcare system on our blog at anthem.com/inmedicaid under Member Materials.

Care management

Healthcare can be overwhelming, so we're here to help you stay on top of it. Your care 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.

Connecting with care management

Providers, nurses, social workers and members or their representatives may refer you to care management in one of two ways:

Phone: 866-902-1690 (TTY 711) • Fax: 855-417-1289

A care manager will respond to a faxed request within three business days.

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 care management program.

Access to complex care management

We use data to find out which members qualify for our complex care management program. You can be referred to complex care management through our:

- 24/7 NurseLine
- Condition Care 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 care management, call Member Services at 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.

Condition Care

Our Condition Care 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 Condition Care Centralized Care Unit (CCCCU) team. Our team of licensed nurses, called CCCCU care managers, will help you understand your condition and help you meet healthcare goals through education, resources, and referrals to providers for care.

You can join the program if you have one of these conditions:

- ADHD
- Asthma
- Autism
- Bipolar disorder
- Coronary artery disease
- Chronic kidney disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive heart failure
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder – Adult
- Major depressive disorder – Child and adolescent
- Pregnancy
- Schizophrenia
- Sickle cell disease
- Substance use disorder

Our care managers can also assist with weight management and smoking cessation services. Your care manager will:

- Listen to you and take the time to understand your specific needs.
- Help you make a care plan to reach your healthcare goals.
- Give you the tools, support and community resources that can help you improve your quality of life.
- Provide health information that can help you make better choices.
- Help you coordinate care with your providers.

How to join

We'll send you a letter welcoming you to a Condition Care program if you qualify. Or, call us toll free at **888-830-4300 (TTY 711)** from 8:30 a.m. to 5:30 p.m. Eastern time Monday through Friday.

When you call, we'll:

- Set you up with a care manager to get started.
- Ask you some questions about your health.
- Start working together to create your plan.

You can also email us at dmself-referral@anthem.com.

Please be aware that emails sent over the internet are usually safe, but there is some risk third parties may access (or get) these emails without you knowing. By sending your information in an email, you acknowledge (or understand) third parties may access these emails without you knowing.

You can choose to opt-out (we'll take you out of the program) of the program at any time. Please call us toll free at **888-830-4300 (TTY 711)** from 8:30 a.m. to 5:30 p.m. Eastern time Monday through Friday to opt-out (leave the program). You may also call this number to leave a private message for your care manager 24 hours a day.

For more information, visit anthem.com/inmedicaid and select **Manage Your Condition** under the **Health & Wellness Resources** tab. You can also call 888-830-4300 or the Behavioral Health Crisis Line at 833-874-0016.

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 and 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
- Condition Care programs
- Transition support

Autism spectrum disorders program

Individuals and families touched by autism can speak with care managers from our autism spectrum disorders (ASD) program. We offer a support system to help members understand the care that's available. Our goal is to help individuals and families gain confidence in navigating the resources available.

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.

Urgent or emergency care?

Which one 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 24/7 NurseLine, even on holidays, at 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 24/7 NurseLine at **866-408-6131 (TTY 711)** 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.

Receiving 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, admission to the hospital, or any other services after you're stable.
- Show your ID card to the hospital or doctor.
- HIP does not cover services provided outside the U.S.

Part 3 – Pharmacy services

Filling your prescriptions

- Your doctor will write you a prescription for medicine you may need.
- Your doctor will then contact your pharmacy, or you can go there with your prescription.
- You must use a pharmacy that's in the Anthem HIP plan. Anthem works with CarelonRx to manage your pharmacy benefits.
- You can find Anthem pharmacies in your plan in our provider directory.
- Your pharmacy benefits have a Preferred Drug List (PDL). The PDL shows some of the drugs covered under the pharmacy benefit.

Find the complete PDL list at anthem.com/inmedicaid in the *Pharmacy Benefits* section.

Pharmacy benefits for HIP members include:

- Prescription drugs.
- Over-the-counter (OTC) items approved by the Food and Drug Administration (FDA) 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.

These prescription drugs are <u>not</u> offered:

- Over-the-counter (OTC) medicines (unless specified on formulary or PDL list)
- Drugs used to become pregnant
- Experimental or investigational drugs
- Drugs for cosmetic reasons
- Drugs for weight loss
- Drugs for hair growth
- Drugs to treat erectile dysfunction

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:

- 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 of a drug 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 within 24 hours after getting your request (not including Sundays or some holidays) if your drug request can be approved. Your doctor will be notified.

Pharmacy copays

HIP members in the Basic Plan have these copays:

- $4 for preferred drugs
- $8 for nonpreferred drugs

There is no pharmacy copay for:

- HIP Plus members.
- HIP Maternity plan members.
- Native American/Alaska Native members.
- Members who have spent 5% 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 non-maintenance drugs or a 90-day supply of maintenance drugs. You can also get that 90-day supply in the mail or at the drugstore. HIP Plus and HIP State Plus members can have the pharmacy set up their 90-day refills for a single date, so you can make one trip to the pharmacy to pick up all 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.

- **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. If you exhaust your appeals, then 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 Family and Social Services Administration within 120 calendar days of receiving our decision about your denial. Send your letter to:

Office of Administrative Law Proceedings
402 W. Washington St., Room E034
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.

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 200 languages. We offer:

- Health education materials translated into different languages and other formats such as braille, large print, or audio CD.
- 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 or oral interpreter (over the phone or face-to-face) 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.

Help for members with hearing or vision loss

Call our toll-free Member Services line at 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 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 866-408-6131 (TTY 711).

Special note to our Native American members

Thank you for choosing Healthy Indiana Plan (HIP). You have a choice to receive traditional Medicaid benefits instead of HIP. You can call the Healthy Indiana Plan Enrollment Broker at 877-GET-HIP-9 (877-438-4497) for questions about changing your health plan. It won't cost anything to change, and you may receive more benefits from traditional Medicaid than from HIP.

Native American Anthem members can receive services from an Indian healthcare provider if eligible. American Indian healthcare providers include providers operated by:

- Indian Health Service (IHS)
- Tribal Organization
- Urban Indian Organization
- An Indian Tribe

Also, if an Indian healthcare provider is in the Anthem plan, you can choose that provider as your PMP.

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

You and your provider can receive a copy of your Member Rights and Responsibilities by mail, fax or email, or on our website at anthem.com/inmedicaid. 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 will also be notified by phone call or mail if benefits, services, or service delivery sites change or end. You can find information about Anthem on our website at anthem.com/inmedicaid. You can also call Member Services at 866-408-6131 (TTY 711).
- Get information about Anthem's structure and operation.
- 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 that the date you joined Anthem is the date your benefits begin, and Anthem will not cover services you received before that date.
- Choose a primary medical provider (PMP) who is part of the network and change your PMP without cause or reason.

- 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 healthcare. This includes the right to refuse treatment.
- Know which hospitals you should use and have access to them.
- 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 healthcare 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.
- Find out how Anthem decides if new technology or treatments should be part of a benefit.
- 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 receiving 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.
- Obtain interpreter services at no charge if you speak a language other than English or if you have hearing, vision, or speech loss.
- Voice complaints or appeals about Anthem, the Plan, or the care that we provide to you.
- 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 866-408-6131 (TTY 711).
- Tell us what you would like to change about your health plan, including the member rights and responsibilities policy.
- Question a decision we make about the care you got from your doctor. You will not be treated differently if you file a complaint.
- Know that Anthem can make changes to your health plan benefits as long as we tell you about them in writing before the changes take effect.
- Know that Anthem does not take the place of workers' compensation insurance.
- 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 them.
- Know you will not be held liable if your health plan becomes insolvent (bankrupt and cannot pay its bills).
- Make an Advance Directive (also called a "living will").
- Know that Anthem, your doctors, or your other healthcare providers cannot treat you differently for these reasons:
  - Your age
  - Your sex or gender identity
  - Your sexual orientation
  - Your race
  - Your national origin
  - Your language needs
  - The degree of your illness, health condition, or disability

Member responsibilities

As a member of this health plan, you have the responsibility to:

- Tell us, your doctor, and your other healthcare 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 (and instructions for care) you, your doctors and your other healthcare providers agree to.
- Do the things that keep you from getting sick.
- Treat your doctor and other healthcare 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 receive 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 Anthem and the Division of Family Resources (800-403-0864) if:
  - You move.
  - You change your phone number.
  - You have any changes to your insurance.
  - Your income changes.
  - 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 healthcare 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 certain healthcare services. We base our decision on two things:

- Whether or not the care is medically necessary.*
- What healthcare benefits you have.

We do not pay or reward doctors or other healthcare 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. If you do not pick a new plan, you will be automatically re-enrolled as long as you are still eligible.

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 **877-GET-HIP-9 (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 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 health plan for any reason during the first 60 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 "just cause" at any time if:

- You have exhausted Anthem's internal grievance process due to receiving 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 healthcare needs.
- There are language or cultural barriers.
- 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 healthcare 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 healthcare benefits.

If you have questions, want to change plans for cause, request the MCE change form, file a grievance, or if you're not satisfied with how we handled a grievance, contact the Healthy Indiana Plan Enrollment Broker at 877-GET-HIP-9 (877-438-4479).

If you have other insurance

Call us at 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.

In some cases, Anthem may have the right to get back payments they made for you if another insurance company made payments for your healthcare. Let us know right away if you were hurt in an accident or if another company made payments for your healthcare. You'll need to let us know information about what happened. **Call the Subrogation department at 866-891-7397 (TTY 711).**

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 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 healthcare. We keep this information private between you, your healthcare 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 866-408-6131 (TTY 711).

Living will (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 healthcare 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 healthcare 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 healthcare. Anthem's Quality Improvement program reviews the services you get from Anthem doctors, hospitals, and other healthcare 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 healthcare.
- 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 healthcare.
- 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 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 healthcare 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 — hospitalcompare.hhs.gov
- Hospital Inpatient Quality Reporting Program — cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalrhqdapu.html
- Physician Quality Information — Indiana Health Information Exchange, found at 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 Health Advisory Network to Gain Equity (CHANGE) Committee by calling Member Services at 866-408-6131 (TTY 711). As part of this group, you can tell us your views and ideas to help us understand what our members need. It will also help us to find out how we can improve the quality and cost of healthcare.

Reporting member or provider fraud and abuse

First line of defense against fraud

We are committed to protecting the integrity of our healthcare program and the effectiveness of our operations by preventing, detecting, and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- **Fraud -** Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it—or any other person. The attempt itself is fraud, regardless of whether or not it is successful
- **Waste -** Includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse -** When healthcare providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

Learn more at fighthealthcarefraud.com.

Presentation of a member identification (ID) card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website, and telephonically.

Members should protect their ID cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to the company as soon as possible. Members should check their explanation of benefits (EOBs) for any errors and then contact member services if something is incorrect.

Reporting fraud, waste and abuse

If you suspect a provider (e.g., provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste, or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person and their information, if supplied, who reports the incident is kept in strict confidence by the Special Investigations Unit (SIU).

You can report your concerns by:

- Visiting our fighthealthcarefraud.com education site; at the top of the page, click "Report it" and complete the "**Report Waste, Fraud and Abuse**" form.
- Calling the SIU fraud hotline at 866-847-8247.
- Calling Member Services at 866-408-6131 (TTY 711).
- Mail a letter to the SIU with your allegation of possible fraud, waste, or abuse to:
  Special Investigations Unit
  740 W Peachtree St. NW
  Atlanta, GA 30308

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of provider fraud, waste, and abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Overutilization
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code

- Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a *provider* (a doctor, dentist, counselor, medical supply company, etc.), include:

- Name, address, and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility, if you have it.
- Type of provider (doctor, dentist, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can help in the investigation.
- Dates of events.
- Summary of what happened.

Examples of member fraud, waste, and abuse:

- Forging, altering, or selling prescriptions
- Letting someone else use the member's ID (identification) card
- Relocating to out-of-service plan area and not notifying us
- Using someone else's ID card

When reporting concerns involving a *member,* include:

- The member's name.
- The member's date of birth, member ID, or case number if you have it.
- The city where the member resides.
- Specific details describing the fraud, waste, or abuse.

If a member appears to have committed fraud, waste, or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our healthcare plan, with state approval.

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.*)

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 Member Services at 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.

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. You, or someone you choose to act for you, can let us know your problem:

- Use the Chat feature on the Sydney Health mobile app.
- Log in to your online account through our secure portal at anthem.com/inmedicaid.
- Call us at **866-408-6131 (TTY 711)**.
- Send us a letter at:
  Anthem Blue Cross and Blue Shield
  P.O. Box 62429
  Virginia Beach, VA 23466

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 *file an appeal.* The information is located in this section.

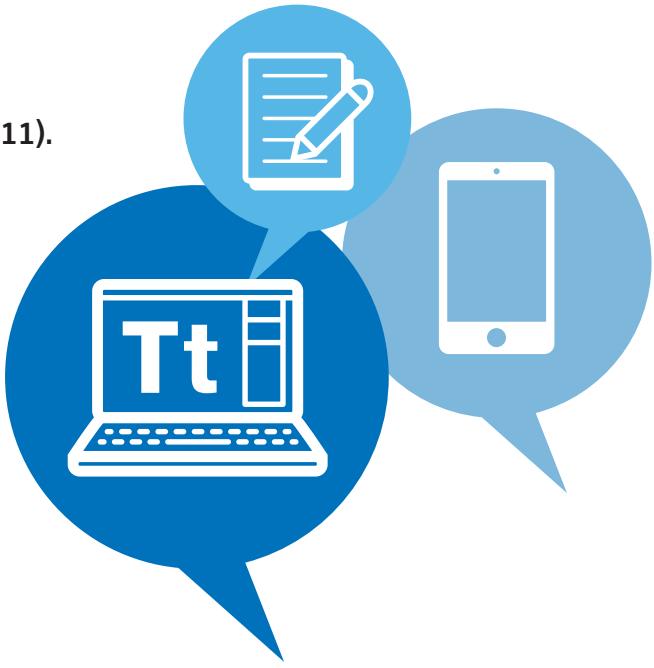
Our Member Services staff will try to take care of your problem right away. They may have to send the information to the right staff person for a final answer. You may choose not to be named when you tell us, or send us information about, your problem.

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.



You have three ways to file a grievance with us:

1. **Call Member Services at 866-408-6131 (TTY 711).**
2. **Complete a grievance form** found on 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 a letter to tell you why we need more time.

Expedited (rush) grievance

Members must request an expedited grievance by fax or calling Member Services. Please contact us in one of these ways:

Member Services: 866-408-6131 (TTY 711)
Fax: 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.

If we don't think waiting 30 calendar days will harm your health, we'll send you a letter within two calendar days to let you know we'll complete your grievance as quickly as we can within 30 calendar days. We'll also try to call you to tell you what we decide.

Appeals

If you want to file an appeal about how we solved your problem, an appeal can be requested within 60 calendar days of the date of the grievance resolution letter or service denial 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 acknowledgment 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 866-408-6131 (TTY 711).

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.

You may keep your benefits while you're waiting for your appeal if:

- You asked for the appeal within 10 days of receiving the adverse notice from Anthem;
- Your request involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired;
- And you request an extension of benefits.

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.

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 and/or request a State Fair Hearing.
- 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 or calling Member Services.
Please contact us in one of these ways:

Member Services: 866-408-6131 (TTY 711)
Fax: 855-516-1083

You may ask us to rush your appeal if you think waiting 30 calendar days may harm your health. Our Appeals Nurse will let you know we got your appeal within 24 hours from the time we received it. We will send you a letter with our decision within 48 hours. If the Appeals Nurse says no to your request for a rush appeal, we'll call and send you a letter with the reason for the denial of the expedited request within two calendar days.

External independent review

If you do not agree with Anthem's appeal decision, you have the right to request an external independent review (EIR) and/or State Fair Hearing. An EIR does not replace your right to appeal a decision to a State Fair Hearing. This process provides a neutral review of benefit decisions made by Anthem.

The EIR is used to resolve 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 Healthy Indiana Plan 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 of Anthem receiving the EIR's decision. The letter will explain:

- Your right to ask for a State Fair 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 **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.

State Fair Hearing and appeal process

If you do not agree with what we decide after completing our appeal process, you can ask for a State Fair Hearing 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.

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

Office of Administrative Law Proceedings
402 W. Washington St., Room E034
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 do not agree 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.

Anthem®

HIPAA notice of privacy practices

The original effective date of this notice was April 14, 2003. This notice was most recently revised in June 2022.

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 healthcare.

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 papers 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 healthcare 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, healthcare 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 healthcare or services before you get them
  - To find ways to make our programs better, and to support you and help you get available benefits and services. We may get your PHI from public sources, and we may give your PHI to health information exchanges for payment, healthcare operations, and treatment. If you don't want this, please visit anthem.com/inmedicaid for more information.
- **For healthcare 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 healthcare, if you tell us it's OK
  - With someone who helps with or pays for your healthcare, 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 will have 30 days to send it to you. If we need more time, we have to let you know. 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. We will have 60 days to send it to you. If we need more time, we have to let you know.
- 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 healthcare, payment, everyday healthcare business, or some other reasons we didn't list here. We will have 60 days to send it to you. If we need more time, we have to let you know.
- 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 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 toll-free at 866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 844-284-1797 (Hoosier Care Connect). If you're deaf or hard of hearing, call TTY 711.

To see more information

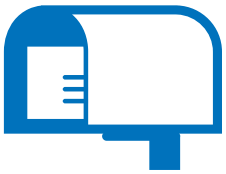
To read more information about how we collect and use your information, your privacy rights, and details about other state and federal privacy laws, please visit our Privacy webpage at https://www.anthem.com/privacy.

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: 800-368-1019
TDD: 800-537-7697
Fax: 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 anthem.com/inmedicaid.

Race, ethnicity, language, sexual orientation, and gender identity

We get race, ethnicity, language, sexual orientation, and gender identity 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.
- Create and send health education information.
- Let doctors know about your language needs.
- Provide interpretation and translation services.

We do **not** use this information to:

- Issue health insurance.
- Decide how much to charge for services.
- Determine benefits.
- Share with 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.

This information is available for free in other languages. Please contact Member Services toll-free at 866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 844-284-1797 (Hoosier Care Connect); TTY 711 Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

anthem.com/inmedicaid

Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

To get this handbook in other languages or alternate formats, such as Braille, large print or audio CD, call Member Services at 866-408-6131 (TTY 711) Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

You can learn more on our website at anthem.com/inmedicaid.

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 866-408-6131 (TTY 711).

Your rights

Do you feel you didn't get these services or we discriminated against you for reasons listed above? If so, you can file a grievance (complaint). File by mail, email, fax, or phone:

Grievance Coordinator
Anthem Blue Cross and Blue Shield
P.O. Box 62429, Virginia Beach, VA 23466
Phone: 866-408-6131 (TTY 711).

Need help filing?

Call our Grievance Coordinator at the number above. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

On the Web:
ocrportal.hhs.gov/ocr/portal/lobby.jsf

By mail:
U.S. Department of Health and Human Services
200 Independence Ave. SW
Room 509F, HHH Building
Washington, DC 20201

By phone:
800-368-1019 (TTY/TDD 800-537-7697)

For a complaint form, visit
hhs.gov/ocr/office/file/index.html.

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.

Spanish

¿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 costo 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.

Arabic

هل تحتاج إلى مساعدة فيما يتعلق برعايتك الصحية أو في التحدث معنا أو قراءة ما نرسله لك؟ نوفر المواد الخاصة بنا بلغات وتنسيقات أخرى مجانًا. اتصل بنا على الرقم المجاني 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan)؛ 1-844-284-1797 (Hoosier Care Connect)؛ الهاتف النصي TTY 711.

Burmese

သင့်ကျန်းမာရေး စောင့်ရှောက်မှု၊ ကျွန်ုပ်တို့နှင့် ပြောဆိုမှု သို့မဟုတ် ကျွန်ုပ်တို့ သင့်ထံ ပေးပို့သည်ကို ဖတ်ရှုမှုအတွက် အကူအညီ လိုအပ်ပါသလား။ ကျွန်ုပ်တို့၏ စာရွက်စာတမ်းများ အခြားဘာသာစကားများနှင့် ပုံစံများဖြင့် အခမဲ့ ရရှိနိုင်ပါသည်။ ဖုန်းခေါ်ခ အခမဲ့ဖြစ်သော 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan)၊ 1-844-284-1797 (Hoosier Care Connect)၊ TTY 711 သို့ ဖုန်းခေါ်ဆိုပါ။

Chinese

您在醫療保健方面、與我們交流或閱讀我們寄送的材料時是否需要幫助？我們免費為您提供用其他語言和格式製作的資料。致電我們的免費電話 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan)；1-844-284-1797 (Hoosier Care Connect)；聽力障礙電傳 TTY 711。

Dutch

Hebt u hulp nodig bij uw gezondheidszorg, wil u met ons praten of lezen wat we naar u sturen? We bieden onze literatuur gratis aan u aan in andere talen en formaten. Bel ons gratis op 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

French

Avez-vous besoin d'aide pour vos soins de santé, pour parler avec nous ou pour lire ce que nous vous 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.	*German*
क्या आपको अपनी स्वास्थ्य देखभाल, हमारे साथ बात करने या हम जो आपको भेजते हैं उसे पढ़ने में सहायता की जरूरत है? हम अन्य भाषाओं एवं प्रारूपों में आपके लिए बिल्कुल मुफ्त अपनी सामग्रियों को प्रदान करते हैं।हमें टोल फ्री नंबर 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711 पर फोन करें.	*Hindi*
お客様のヘルスケアについて、お問い合わせの際やお手元に届く資料に関し、サポートが必要ですか？資料は他言語にて、また読みやすい文字の書式を無料にて提供しております。詳しくはフリー ダイヤル 、1-866-408-6131 (Hoosier Healthwise、Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711までお問い合わせください。	*Japanese*
건강 관리에 도움이 필요하십니까? 아니면 저희와 연락하시거나, 보내드린 자료를 읽는 데 도움이 필요하십니까? 자료를 다른 언어 및 형식으로 무료로 제공해드립니다. 저희에게 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711 번으로 연락해 주십시오.	*Korean*
Brauchscht du Helfe mit dei Health Care, schwetze mit uns odder lese was mir dir schicke? Mir kenne unsere Materials in annere Schprooche un Formats mitaus Koscht gewwe. Ruf uns mitaus Koscht uff: 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.	*Pennsylvania Dutch*
تہانوں اپنی نگہداشتِ صحت، ساڈے نال گل بات کرن یا جو اسی بھیجنے آں اُونہوں پڑھن وچ مدد دی لوڑ اے؟ اسی تہانوں اپنے امواد ہور زباناں تے فارمیٹس وچ مُفت فراہم کردے آں-سانوں ایناں ٹال فری نمبراں تے مُفت کال کرو 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.	*Punjabi*

Russian

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.

Tagalog

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.

Vietnamese

Quý vị 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.


Anthem