Anthem

YOUR RIGHTS AS A HOOSIER HEALTHWISE, HEALTHY INDIANA PLAN OR HOOSIER CARE CONNECT MEMBER

Helping you feel better is why we're here, but if you're not happy with Anthem Blue Cross and Blue Shield, you may:

- File a grievance with Anthem.
- Appeal a grievance resolution (if you're not happy with the outcome of the grievance).
- File an appeal with Anthem for a service that:
  - Has been denied.
  - Has a partial OK (this includes the type or level of the service).
  - Has been changed.
  - Has been stopped.
  - Has been approved and then stopped.
- Ask for an external independent review (EIR) (if you're not happy with the outcome of the appeal of a denied service).
- Ask for a state fair hearing with the Indiana Family Social Services Administration (FSSA) **after** using our appeal process.

Tobacco Surcharge Appeal Rights (HIP members only):

As a HIP member, if you're listed as a tobacco user and you think our information is wrong, you can request to have it corrected. Just call Anthem at 1-866-408-6131. You can also file an appeal if you went through the health plan selection process in your second benefit year and are still marked as a tobacco user.

Grievances

If you're not happy with us or our providers, or don't agree with a decision we have made, you or the person you choose to represent you may file a grievance with Anthem. A grievance is a request to look into an issue that has to do with quality of care or quality of service. You may file a grievance by calling us at 1-866-408-6131 (Hoosier Healthwise and Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711. You also may fill out a grievance form or write a letter and send it to us. Clearly state:

- Who is involved in the grievance.
- What happened.
- When it happened.
- Where it happened.
- Why you're not happy with your health care services.

Attach any documents that will help us look into your issue. You can find grievance forms on our website at www.anthem.com/inmedicaid or at the places you get care, such as your doctor's office. Mail your completed form or letter to:

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

We'll research your issue and make a decision within 30 calendar days from the time we get the grievance. We'll send you a letter with our decision within five business days of making the decision.

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

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

Grievance Appeals

If you're not happy with the decision we made on your grievance, you may appeal a grievance. You may ask for the grievance appeal by calling us at 1-866-408-6131 (Hoosier Healthwise and Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711. You also may fill out a grievance form or write a letter to us. Clearly state:

- Why you're appealing our decision.
- Who is involved in the grievance.
- What happened.
- When it happened.
- Where it happened.
- Why you're not happy with your health care services.

Attach any papers that will help us look into your issue. You can find grievance forms on our website at www.anthem.com/inmedicaid or at the places you get care, such as your doctor's office. Mail your completed form or letter to:

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

You must ask for the grievance appeal within 60 calendar days from the date on the grievance resolution letter. We'll set up a Grievance Appeal Panel meeting. The panel will review your appeal. You may attend this meeting in person or by phone. We'll send you a letter with the date and time of the meeting. At the meeting, you may present information that you wish the panel to take into account about your grievance appeal. You will have 15 minutes to present your information.

The panel will make a decision within 30 calendar days from the date we got your grievance appeal. We'll send you a letter with the appeal panel's decision within five business days after the panel makes a decision.

Expedited Grievance Appeals

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 appeal. In your request, tell us why you think waiting 30 calendar days would harm your health. **Fax your expedited request to 1-855-516-1083.**

You also need to show facts proving your claim. This needs to be done within a certain time period. A medical director looks at requests for faster appeals. If the medical director thinks waiting 30 calendar days won't harm your health, we'll send you a letter within two business days. The letter will let you know we'll complete your appeal as quickly as we can within 30 calendar days. Also, we'll try to call you to tell you what we decide.

We'll set up a Grievance Appeal Panel meeting within 48 hours from the time we get your grievance appeal. The panel will review your appeal. You may attend this meeting in person or by phone. We'll call you with the date and time of the meeting. At the meeting, you may present information that you wish the panel to take into account about your grievance appeal. You will have 15 minutes to present your information.

The panel will decide within 48 hours from the date we get your grievance appeal. We'll try to call you to tell you what we decide. We'll send you a letter to tell you what the appeal panel decides within five business days after we make a decision.

Service Appeals

You may ask for an appeal if you receive a Notice of Action letter from us telling you a medical service:

- Has been denied.
- Has been changed.
- Has been approved and then stopped.
- Has not been given in a timely manner.

You must ask for an appeal within 60 calendar days from the date on the Notice of Action letter. Appeals must be in writing and should be sent to:

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

If you need help, please call 1-866-408-6131 (Hoosier Healthwise and Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

We'll review the issues and make a decision within 30 calendar days from the time we get your appeal. We'll send you a letter with our decision within five business days of making the decision.

Expedited Service Appeals

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) appeal. In your request, tell us why you think waiting 30 calendar days would harm your health. **Fax your expedited request to 1-855-516-1083.**

Also, you need to show facts proving your claim. This needs to be done within a certain time period. A medical director reviews requests for faster appeals. If the medical director thinks waiting 30 calendar days won't harm your health, we'll send you a letter within two business days. The letter will let you know we'll complete your appeal as quickly as we can within 30 calendar days. Also, we'll try to call you to tell you what we decide. We'll send you a letter with our decision within five business days after we make our decision.

For All Service Appeals

If you need more time to send in information, you may add up to 14 calendar days to the appeal time. We also may add up to 14 calendar days to the appeal time if we need more information and the delay is best for you. We'll send you a letter with the reason for the delay.

You, or the person you choose to represent you, may look at your case file. (This includes medical records or other papers that are taken into account during our appeal process.) At any time during the appeal process, you may ask us for a copy of the paperwork we used to make this decision free of charge, including:

- The benefit terms
- Guidelines
- Rules
- Other reasons

Your doctor may wish to speak to the reviewing doctor. Ask your doctor to call our Utilization Management (UM) department at:

- **1-866-408-6132 – Hoosier Healthwise**
- **1-844-533-1995 – Healthy Indiana Plan**
- **1-844-284-1798 – Hoosier Care Connect**

You may keep your benefits while the appeal is pending if you meet **all** of these conditions:

- You asked for the appeal within 10 calendar days from the date we mailed the Notice of Action letter.
- The appeal has to do with a service that had been:
  - Delayed.
  - Reduced.
  - Stopped after it was approved.
- The services were ordered by an approved provider.
- The first period of coverage by the first OK has not ended.
- You asked to extend your benefits.

If we agree to let you keep your benefits while the appeal is pending, they will be in effect until one of these happen:

- You withdraw your appeal request.
- Ten days pass after we send you a Notice of Action letter with our decision to uphold the first denial (unless you asked for a state fair hearing within that 10-day period).
- A state fair hearing officer upholds our denial.
- The time period of a service that was approved before has been met.

Charges may apply if the final outcome of your appeal upholds the denial. Call us if you have questions at 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

External Independent Review

You or the person you choose to represent you may ask for an External Independent Review (EIR) if these apply:

- You have used our appeal process.
- You received an appeal letter telling you one of these things:
  - Your services are being denied.
  - Your services are being denied for medical need.
  - A planned service is still being researched or looked into.

You must send your request for an EIR in writing to:

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

We must receive your request within 60 calendar days of the date on the appeal letter. We'll send all the records we have to an EIR group that has been approved by the Department of Insurance.

If you present any new information that we didn't have a chance to review during the normal appeal process, the EIR will be stopped. We'll review this new information and make a decision. We'll tell you what we decide within 15 business days from the time we get the information. If you asked for an expedited (faster) EIR **by faxing your request to 1-855-516-1083**, we'll review the information and tell you what we decide within 48 hours from the time we get the information.

If we decide to uphold the denial, you may ask that the EIR continue.

The EIR group must make its decision within 15 business days after the request was filed. The group will tell you and us within 72 hours after it decides. If you asked for a faster EIR, the EIR group will decide within 72 hours after the request was filed. The group will tell you and us within 24 hours after it decides.

Anthem needs to follow what the EIR decides. We'll tell you of any actions that we take within 72 hours after the EIR group's decision. If you asked for a faster EIR, we'll tell you of our actions within 24 hours of the EIR group's decision. You may keep your benefits while the appeal is pending if you meet **all** of these conditions:

- You asked for the appeal within 10 calendar days from the date we mailed the Notice of Action letter.
- The appeal has to do with a service that had been:
  - Delayed.
  - Reduced.
  - Stopped after it was approved.
- The service was ordered by an approved provider.
- The first period of coverage by the first OK has not ended.

If we agree to let you keep your benefits while the appeal is pending, they will be in effect until one of these happens:

- You withdraw your appeal request.
- Ten days pass after we sent you a Notice of Action letter with our decision to uphold the first denial (unless you asked for a state fair hearing within that 10-day period).
- A state fair hearing officer upholds our denial.
- The time period of a service that was approved before has been met.

Charges may apply if the final outcome of your appeal upholds the denial. Call us if you have questions at 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

State Fair Hearing

If you're not happy with our response to your appeal, you or the person you choose to represent you has the right to ask for a state fair hearing with the FSSA. You must:

- First use our appeal process.
- Send your request in writing within 60 calendar days from the time you were notified of Anthem's decision to deny your appeal.

You may mail your request for a state fair hearing to the FSSA at:

Hearings and Appeals Section, MS-04
Indiana Family Social Services Administration
402 W. Washington St., Room W392
Indianapolis, IN 46204-2273

The FSSA will contact you to discuss your case. The FSSA also will set up a hearing date.

You may keep your benefits while the hearing is pending if you meet **all** of these conditions:

- You asked for the hearing within 10 calendar days from the date we mailed the appeal Notice of Action letter.
- The hearing has to do with a service that has been:
  - Delayed.
  - Reduced.
  - Stopped after it was approved.
- The service was ordered by an approved provider.
- The first period of coverage by the first OK has not ended.
- You asked to extend your benefits.

If we agree to let you keep your benefits while the hearing is pending, they will be in effect until one of these happens:

- You withdraw your hearing request.
- A state fair hearing officer upholds our denial.
- The time period of a service that was approved before has been met.

Charges may apply if the final outcome of your appeal upholds the denial. Call us if you have questions at 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

www.anthem.com/inmedicaid **Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect**