Member Handbook
Anthem Blue Cross and Blue Shield

Effective 2015

We can translate this free of charge. Call 1-866-408-6131; TTY 1-866-408-7188.

Podemos traducir esta información sin costo. Llámenos al 1-866-408-6131; TTY 1-866-408-7188.

To get this handbook in other formats, such as Braille, large print or audio CD, call our Customer Care Center at 1-866-408-6131 (TTY 1-866-408-7188).

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

I’m Dr. Kimberly Roop, Medical Director at Anthem Blue Cross and Blue Shield. I’m a physician and part of a team of dedicated doctors, nurses and other Anthem employees who are here to improve your health and the health of our communities. Anthem has been honored to serve Hoosier Medicaid recipients since 2007.

We know that life is complicated and fitting everything into your busy day is hard. We are committed to doing everything we can to help you get the care you need and deserve. Now that you are an Anthem member, here are some important things to do right away:

- Pick your primary medical provider (PMP) and make an appointment for a checkup right away. We can help you if you need help making an appointment.
- Fill out your Health Needs Screening right away — see the informational sheet in your member packet for instructions. If you do it within 90 days, we will give you a gift card!
- Choose HIP Plus: HIP Plus is the preferred plan for all HIP members. HIP Plus provides the best value coverage and includes vision and dental services. In HIP Plus, members pay affordable monthly contributions based on income and do not pay any other costs or copayments unless they go to the emergency room when they don’t have an emergency health condition.
- If you are a HIP Plus Plan member, pay your contribution on time every month.
- Keep your member ID card with you at all times. Show it every time you need health care services.

Thank you for joining Anthem. We work with the state of Indiana to bring you the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) health insurance programs. Now that you are part of the Anthem family, we want to make sure you make the most of your benefits to keep you healthy. This member handbook will tell you how to use your new health plan.

Here is what you will find inside:

- How your health plan works
- Which services are covered and which are not
- How to get help if you don’t understand part of your plan
- How you can get help if you have a problem with Anthem or a health care provider
- Your member rights and responsibilities
- How we keep your information private
- Programs to help keep you well
- Phone numbers to call if you need to talk to a registered nurse or want access to more than 300 audio health topics
- How to make payments (for HIP Plus members)

Thank you again for choosing us as your family’s health plan.

Sincerely,

Kimberly Roop, MD
Medical Director
Anthem Blue Cross and Blue Shield
Special note to our Native American members
Thank you for choosing HIP. You have a choice to receive traditional Medicaid coverage instead of HIP. You can call the Family and Social Services at 1-800-403-0864, or complete a Change Form to change from HIP to traditional Medicaid. It won’t cost anything to change and you may receive more benefits from traditional Medicaid than from HIP.

Stay connected! Please report any changes in your phone number or address.

Call Family and Social Services at 1-800-403-0864 if your information changes.

They will update their records and send changes to us. You can also visit your local Division of Family Resources (DFR) office or submit your changes online. Go to www.in.gov/fssa. Click the “Apply for Benefits Online” button and follow the instructions for submitting changes in your information.

We offer many great benefits!
- Many doctors to choose from — and changing doctors is easy
- Cell phone with 250 minutes each month and unlimited texting, plus a one-time bonus of 200 minutes
- Transportation to your doctor appointments (WIC appointments and redetermination appointments also included)
- Rewards for certain preventive care visits and completing a health survey
- Subscriptions to Parenting magazine and Eating Well magazine
- Future Moms program for pregnant women
- Disney® Habit Heroes smartphone app
- Local classes and programs to help you with healthy living
- Kits to teach kids how to eat well and stay active
- Sports physicals for children with their assigned provider
- Access to a nurse to help you with your health care

Plus, HIP members get:
- Post-inpatient surgical meals — two meals per day for up to seven days with your doctor’s order at no cost
- YMCA membership for HIP members in Plus and State plans

Questions or Comments?
If you have any questions, please call our Customer Care Center (CCC) toll free at 1-866-408-6131, Monday through Friday from 8 a.m. to 8 p.m. Members with hearing or speech loss may call our CCC TTY line at 1-866-408-7188.

You also may call the 24/7 NurseLine, the nurse help line, to talk to a nurse toll free, 24 hours a day, seven days a week at 1-866-800-8780 (TTY 1-800-368-4424).
How to use this book
We’ve put this book into parts so you can find what matters most to you at any time. Please make sure you know:

• How to use your Anthem health plan
• What Anthem covers and does not cover
• How your POWER Account works (for HIP members)
• Filling your prescriptions
• About emergency and urgent care
• How to resolve a problem with Anthem
• About programs to help keep you well
• Your health care rights and responsibilities
• Important phone numbers
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Part 1 – How to use your Anthem health plan

How do you find your network of doctors and providers?
Go to your Provider Directory to find out about your Hoosier Healthwise (HHW) or Healthy Indiana Plan (HIP) network and how to look for a provider.

Your ID card
It’s important to keep your state Hoosier Healthwise ID card or Anthem Healthy Indiana Plan ID card with you at all times. If you are a HHW member, your state Hoosier Healthwise ID card helps providers know you are an Anthem member. If you are a HIP member, your ID card shows that you are an Anthem health plan member and that you have the right to get covered health care. Show this ID card every time you need health care services. Only you can get health care services with your ID card. Do not let anyone else use your card.

As a HIP member, your Anthem ID card is also your HIP POWER Account debit card. When you use your ID card for care, the funds come right from your POWER Account. Remember that preventive care services will not be charged to your POWER Account. Your POWER Account cannot be used to pay copays or noncovered services.

If you get services or benefits that are not covered or you are not a member of our health plan at the time of service, you may have to pay the cost for that service. If you lose your card, you can request a replacement card by signing in to MyAnthem at www.anthem.com/inmedicaid or by calling our Customer Care Center at 1-866-408-6131 (1-866-408-7188).

What is a primary medical provider (PMP)?
Your primary medical provider, or PMP, is your medical home and point of contact for all your health care needs. They will help you get the health care you need at any time, even if it is after office hours, and will respect your cultural and religious beliefs. Your PMP will take care of all your health care needs by coordinating:
- Checkups and vaccines
- Requests to get an OK to give you services if needed
- Referrals to specialists
- Referrals for tests and services
- Admission to a hospital

Your PMP can be any of these types of providers:
- Pediatrician (a doctor who takes care of babies and children)
- Family and general practitioner (a doctor who takes care of babies, children and adults)
- Internist (a doctor who takes care of adults)
- Obstetrician/gynecologist, also called an OB/GYN (a doctor who takes care of women only)
- Doctors at clinics such as health departments, federally qualified health centers (FQHCs) and rural health clinics (RHCs) also can be PMPs

You can also see a nurse practitioner who will work with your PMP.
Initial health exam
Make an appointment to see your PMP to get a checkup. Your PMP will:

- Get to know you and talk about your health.
- Introduce you to the office staff and explain how office rules work.
- 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 necessary tests and preventive services.

Making an appointment with your PMP
Call your PMP’s office for an appointment and tell them you are an Anthem member. Have your ID card with you when you call. You may be asked for your member ID number. Make sure to bring your ID card with you to each doctor visit.

Please call your PMP’s office as soon as you can if you will be late or if you cannot keep your appointment. If you cancel your appointment, someone at your doctor’s office can help you schedule a new one.

Changing your PMP
It is best to keep the same doctor so he/she can get to know your health needs. If you choose to go to a doctor who is not your PMP or want to change your PMP, call us first. If you see a doctor who is not your PMP without an OK from us first, you may have to pay for the services you get.

If you want to change your PMP, call our Customer Care Center toll free at 1-866-408-6131 (TTY1-866-408-7188). We can help you try to find a PMP who is close to your home.

Continuity of care
We are here to help new members get continuing care and coordination of medically necessary health care when they join Anthem. If you want to know if continuity of care is for you, call the Customer Care Center.

Services from providers who are not in your network
Call your PMP, other network provider or us to find out if you need an OK ahead of time for services from a provider who is not in your network. You may be able to see a provider who is not in our network for self-referral. (See Part 2 What Anthem covers and does not cover.) We can only give an OK for providers that are part of the Indiana Health Care Programs (IHCP) — which means they are part of the state’s network.

If you get a service from a provider that is not in your network or the service is not an approved service, it will be considered an out-of-network service. This does not apply to some self-referral services. See Part 2 What Anthem covers and does not cover.
**Indiana Right Choices program**

If you’re enrolled in this program, we will send you a letter to let you know. A team of experts will help you get the right health care at the right time in the right place. Your team will be made up of a PMP, a pharmacy, a hospital and a care manager. If you have questions about the Right Choices program, call **1-866-408-6131 (TTY 1-866-408-7188)**.

**Provider Directory**

Use the provider directory or the Find a Doctor tool online to find a PMP who is right for you or your family member.

There are a number of ways you can find a provider:

- You can request a provider directory in the mail. Look in your member packet to find instructions on requesting a provider directory.
- You can go online at www.anthem.com/inmedicaid and click on *Find a Doctor*.
- You can get the Anthem Mobile Provider Finder app for your cellphone online at www.anthem.com/mobile.
- You can always just give us a call.

Our provider directory and Provider Finder tools tell you:

- Names and addresses of network 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).

**Hoosier Healthwise members (including HIP Maternity)** — Choose providers in the Anthem Blue Cross Blue Shield (Hoosier Healthwise) network. To choose St. Francis providers, use the network called St. Francis Hoosier Healthwise.

**Healthy Indiana Plan members (Including HIP Basic or HIP State Plan)** — Choose providers in the Healthy Indiana Plan network. You need to choose a PMP who can take new patients unless you were already a patient of that PMP before you joined Anthem.

To learn more about a PMP or a specialist (such as the doctor’s specialty, medical school, residency training or board certification), visit these websites:

- Medical Licensing Board of Indiana at [www.in.gov/pla/medical.htm](http://www.in.gov/pla/medical.htm) (You also may call them at **1-317-234-2060**.)
- American Medical Association (AMA) at [https://extapps.ama-assn.org/doctorfinder/recaptcha.jsp](https://extapps.ama-assn.org/doctorfinder/recaptcha.jsp) (Click the word “Patients” at the top right of the page.)
- American Board of Medical Specialties (ABMS) at [www.abms.org](http://www.abms.org)
- Anthem at [www.anthem.com](http://www.anthem.com)
If you need a provider directory or need help choosing a doctor who is right for you, call our Customer Care Center toll free at 1-866-408-6131 (TTY1-866-408-7188).

**Prior authorization (an OK from Anthem)**

Your PMP will need to get an OK from us for some services to make sure they are covered. This means that both Anthem and your PMP (or specialist) agree that the services are medically necessary.

“Medically necessary” means a service is reasonably needed to:

- Protect life.
- Keep you from getting seriously ill or disabled.
- Reduce severe pain through the diagnosis or treatment of disease, illness or injury.

Getting an OK will take no more than seven calendar days or, if urgent, no more than three days. See **Part 2 What Anthem covers and does not cover** to check your benefits. Your PMP can tell you more about this.

We may ask your doctor why you need special care. We may not OK payment for a service you or your doctor asks for. If we decide that a service is not covered, we will send you and your doctor a letter that tells you why we made this decision. The letter also will let you know how to appeal our decision. To learn more about appeals, see **Part 6 How to resolve a problem with Anthem**.

If you have questions, you or your doctor may call us at our Customer Care Center toll free at 1-866-408-6131 (TTY 1-866-408-7188), or you may write to us at:

**Anthem Blue Cross and Blue Shield**

P.O. Box 6144

Indianapolis, IN 46206-6144

**Self-referral**

You can get some services without a referral from your PMP or an OK from us. This is called self-referral. Please see **Part 2 What Anthem covers and does not cover** to learn more about this.

**Urgent care**

An urgent medical condition is NOT an emergency, BUT needs medical care within 24 hours.

Call your PMP if you have an urgent medical condition. If you cannot reach your PMP, follow these steps:

- Call us at our Customer Care Center toll free at **1-866-408-6131 (TTY 1-866-408-7188)**, Monday through Friday from 8 a.m. to 8 p.m.
- Call the 24/7 NurseLine at **1-866-800-8780 (TTY 1-800-368-4424)**.
- You can go to a participating urgent care center. You can find a list of the urgent care centers in your network in our provider directory and at the Find a Doctor tool (online at www.anthem.com/inmedicaid).
Emergency care
An emergency is a medical condition with such severe symptoms (including severe pain or active labor) that you reasonably believe that not getting medical attention right away may:

- Place your mental or physical health (or the health of your unborn child) in jeopardy.
- Cause impairment to a body function.
- Cause disfigurement.
- Cause dysfunction of a body organ or part.

If you have an emergency, call 911 or go to the nearest emergency room (ER) for emergency care any time of the day or night.

Go to the nearest hospital if you think you need medical attention right away. You do not need an OK from us. The hospital does not have to be in the Anthem network.

You can use any hospital or other setting for emergency care. If you get sick while out of town or out of the state you live in and you have a medical emergency, go to the nearest emergency room or call 911.

If you are not sure whether or not you need to go to the ER or if you would like to talk to a nurse about how you are feeling, please call our 24/7 NurseLine. A registered nurse can help you.

HIP copay for ER
If you choose to use the emergency room when you do not have an emergency health condition, you will have to pay a copayment. The first time you use the emergency room when you do not have an emergency health condition, this copayment will be $8. After the first time, you will have to pay $25 every time you use the emergency room when the health condition is not an emergency. If you call the 24-hour nurse helpline and are told to go to the emergency room, then you will not be responsible for making any copayment.

The hospital will collect the HIP emergency room (ER) copay from you. POWER Account funds cannot be used to pay the copay. You only have to pay the ER copay if your visit is NOT considered an actual emergency.

Note: HHW members do not have a copay for valid ER services. Native Americans and Pregnant Members do not have to pay a copay for valid ER services.

The doctors at the emergency room will tell you before giving you nonemergency services:

- That you need to pay the copay before getting the service.
- The name and location of another nonemergency services provider that can treat you and is easy to get to.

That another provider can give you the service without having to pay the copay.
Getting emergency care outside our service area
If you need emergency care while you are traveling outside of our service area, follow these steps to help make sure you are covered:
- Call your PMP or have the hospital call your PMP if you need surgery or admission to the hospital or any other services after you are stable.
- Show your ID card to the hospital or doctor.

HIP and HHW Plans do not cover services provided outside the U.S.

Post-stabilization
This care is the services you get in the emergency room or hospital after your condition is stable, but before you leave the emergency room or hospital. Anthem covers this type of care at no charge to you.

Hoosier HealthWatch — Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/Well-child visits

We want your children to get the best care and be healthy. EPSDT services are covered for children to 21 years of age, including those members age 19 and 20 enrolled in any HIP product.

You can help keep your child healthy if:
- You take them to their primary medical provider (PMP) for routine checkups and vaccines (shots).
- You take them to their dentist for routine visits.

Anthem follows the guidelines from the American Academy of Pediatrics for well-child visits. These steps will help keep your children healthy and strong.

Protecting your family from lead poisoning
All children enrolled in Medicaid must have a blood lead level (BLL) test at both 1 and 2 years of age. They must take a BLL test at least once by age 6 or if they are at risk. If you check one or more of the boxes below, have your child take a BLL test right away. Does your child:
- 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?
- Visit or live in a house built before 1978 (such as the home of a relative or babysitter, a day care center, or a preschool)?
- Often visit an adult who works with lead (such as pottery, painting, construction or welding)?

See the Preventive Health Guidelines that are available on our website, www.anthem.com/inmedicaid, to learn more about when you should set up your child’s well visits and shots.
Smoking cessation
Anthem can help you stop smoking. To receive information about smoking cessation, call our Customer Care Center toll free at 1-866-408-6131 (TTY 1-866-408-7188). We cover one 12-week course of care per 12 months, which includes:
- Prescription or over-the-counter products to help you stop smoking, such as nicotine patches or gum.
- Counseling services (a limit of eight hours of counseling services).

Pregnancy care
As soon as you know you are pregnant, call our Customer Care Center toll free at 1-866-408-6131 (TTY 1-866-408-7188). You will also need to see your doctor to begin prenatal care. Our staff will make sure that your doctor and the hospital where you will have your baby are both in your network.

HIP Members:
Because you are pregnant, you could choose to switch to HIP Maternity benefits. Whether you stay in your current HIP program or move to HIP Maternity you will receive additional benefits including non-emergency transportation services to medical appointments.

While pregnant you will not be responsible for any contributions to the POWER Accounts or copayments when you receive health care services. These POWER Account contributions or copayments will be suspended for the remainder of your pregnancy.

As a HIP member, you can remain in your current HIP program (HIP Plus or HIP Basic) during your pregnancy. However, if your 12-month HIP benefit period ends while you’re pregnant, you will be moved to the HIP Maternity plan for the remainder of your pregnancy. This program is part of HHW.

Whether you stay with your HIP Plan or change to HHW, you will have maternity benefits, and we will be here to help you. You can get more information by calling our Customer Care Center toll free at 1-866-408-6131 (TTY 1-866-408-7188).

HIP Maternity Plan
If you qualify for HIP based on your family income level, you are a HIP member even during pregnancy. When you receive your enrollment letter, you will be told if you are enrolled in HIP. If you qualify for HIP and you are pregnant at the time of enrollment, you will be enrolled in the HIP Maternity Plan. This is because the regular HIP Plan only includes maternity benefits for members who are already enrolled in HIP when they become pregnant.

At the end of your pregnancy, you will receive an additional 60 days of postpartum coverage. At the conclusion of your 60 day postpartum period, you will be re-enrolled in HIP Plus without a gap in coverage as long as you:
- Report the end of your pregnancy to the Family and Social Services Administration by calling 1-800-403-0864 within ten (10) days after the pregnancy ends; and
- Make your required POWER account contribution prior toward the end of the postpartum period.
Once re-enrolled in HIP Plus, you will need to resume making your monthly POWER account contributions.

If you do not take the above actions, you may face a gap in coverage at the end of your postpartum coverage or your coverage may be terminated, and you may need to reapply.

**Future Moms** is our program for pregnant women. As part of this prenatal program, we will send you information on how to take care of yourself during pregnancy and after delivery and how to prepare for your new baby. You can call us at 1-877-337-5640 to sign up for this program.

**Family planning services**
Family planning can help teach you how to:
- Be as healthy as you can before you become pregnant.
- Keep you or your partner from getting pregnant.
- Help you to plan or space your pregnancies.
- Keep you or your partner from getting sexually transmitted infections.

Any member (adult or minor) may see any qualified family planning provider that contracts as an Indiana Medicaid provider without getting an OK from us first. This includes providers outside your network, such as:
- Clinics
- OB/GYNs
- PMPs
- Certified nurse-midwives

**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 referred to you.
- Tell your PMP and the specialist as much as you can about your health so all of you can decide what is best.
- Any specialist or other provider not in your network must get an OK from us before they can give you care. You may also need the referral from your PMP.

**Standing referral**
Anthem allows members with special needs who need ongoing treatment or regular monitoring to see a specialist for treatment through a standing referral from your PMP. The treatment given by the specialist must be right for your health issue and needs. To learn more about this, call our Customer Care Center toll free at 1-866-408-6131 (TTY 1-866-408-7188).
Getting a second medical opinion
You may have questions about care that your doctor says you need. You may want a second opinion to:
- Diagnose an illness.
- Make sure the treatment plan is right for you.

To get a second opinion, talk to your PMP or call us. To learn more about second opinions, call our Customer Care Center.

Case management
Our case management program helps you manage your health care. If you have health problems such as:
- Diabetes
- Asthma
- Heart failure
- Behavioral health issues

A nurse case manager or social worker will:
- Work with you to help manage your health care needs.
- Help you better understand your diagnosis.
- Work with you and your doctor to set up and meet personal goals to improve your health and quality of life.

If you have one of these health issues or another complex or special health issue and want to learn more about case management, call our Customer Care Center toll free at 1-866-408-6131 (TTY 1-866-408-7188).

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

We do not pay doctors or other health care workers to:
- Deny you care.
- Say you do not have coverage.
- 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.
These services meet the standards of good medical practice within the organized medical community. To learn more about how medical coverage decisions are made, call our Customer Care Center toll free at 1-866-408-6131 (TTY 1-866-408-7188).

**Important Note**
Some hospitals and providers may choose not to perform a service because of their beliefs. They can choose this even if the health care service is a covered service. Some examples are:

- Family planning
- Contraceptive services (includes emergency contraception) to prevent pregnancy
- Sterilization (includes tubal ligation at the time of labor and delivery) to prevent pregnancy
- Infertility treatments (to help a family have children)
- Abortion (choosing to end a pregnancy)

You can find out more before you select a provider. You can call us or the doctor or clinic you plan to use.

**HIP Members: Your benefits and your Personal Wellness and Responsibility (POWER) Account works**

In the Healthy Indiana Plan (HIP), the first $2,500 of medical expenses for covered benefits are paid with a special savings account called a Personal Wellness and Responsibility (POWER) account. The state will contribute most of this amount, but you will also be responsible for making a small contribution to your account each month. The amount of your contribution amount is based on your income.

Managing your account well and getting preventive care can reduce your future costs. If your annual health care expenses are less than $2,500 per year, you may roll over your remaining contributions to reduce your monthly payment for the next year. You can also have this reduction doubled if you complete preventive services. Your health plan will let you know what preventive care services are recommended for you. If your annual health care expenses are more than $2,500, the first $2,500 is covered by your POWER account, and expenses for additional health services over $2,500 are fully covered at no additional cost to you (unless you are in the HIP Basic program and are responsible for any copayments).

In HIP, your contributions to your POWER account will be yours, and you could receive a portion back if you leave the program. Since your contributions are based on a projected annual amount, you may also be responsible for paying the contributions for any remaining months of enrollment if you leave the program early after having significant health care expenses.

**HIP Plus Plan POWER Account contribution payments**
If you’re in the HIP Plus Plan, you must make payments to pay your part of the POWER Account. These payments are called contributions. You will get a bill each month for the payment you need to make.
HIP Plus plan members pay monthly payments to contribute to their POWER Account. No additional payments are required, except if you use a hospital emergency room for a non-emergency situation. Then you would pay $8 – $25.

Members who don’t pay their monthly POWER account contribution will lose their HIP Plus coverage. Monthly payments must be made on time. If your payment is more than 60 days late, you will be termed from the HIP Plus plan.

HIP members who do not pay their monthly POWER account contributions are disenrolled from HIP Plus. Those with incomes of $973 or less per month for an individual or $1,988 or less per month for a family of four will receive HIP Basic benefits. If your income is more, you will be termed from the Healthy Indiana Plan. If you are termed for non-payment, you will have to wait six months to apply again for HIP.

HIP Basic requires members to make a payment every time they receive a health care service. These are called co-payments. HIP Basic plan copayments are $4 for each separate physician or other outpatient service. The copayments for prescriptions are $4 – $8. A hospital admission copayment is $75. Copayments can quickly add up. The HIP Basic plan can be much more expensive than the HIP Plus plan. If you are moved to the HIP Basic plan due to non-payment, you won’t be able to move back to the HIP Plus product until you begin a new 12-month benefit period.

You are responsible for paying your part of the POWER Account. If you leave the program before 12 months, you may still owe money for your POWER Account. If we have paid claims from your POWER Account, we will determine if you already paid enough to cover the cost. If your part of the claim amount is more than what you already paid, we will bill you for the rest. If we didn’t pay claims from your account, your part will be refunded to you, but you could be charged a 25-percent penalty.

There are a number of easy ways for HIP Plus member to make payments. Choose the one that’s best for you:

1. Mail — Send the form with your check or money order to:
   
   Anthem BCBS IN HIP  
   P.O. BOX 105674  
   Atlanta, GA 30348-5674

2. Bank draft — Have your payments taken from your checking account each month. To set this up, contact our Customer Care Center toll free at 1-866-408-6131 (TTY 1-866-408-7188).

3. Online through Anthem — Make your payment at our website. You’ll need to register online at www.anthem.com.

4. 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 when you use an online bill pay service.
5. Walmart — Pay with cash or a debit card with a PIN at your local Walmart store. Just show your current monthly statement and allow five days to post to your account. Walmart charges 88 cents for this service.

6. Telephone — Pay by credit card by calling our Customer Care Center. Allow at least five days for your payment to post.

**If you pay by check and it’s returned:**
You will have to pay a $20 fee. Also, the money will be reversed from your checking account. This may cause you to be past due in payments. Your health plan will end if your POWER Account is more than 60 days past due. If this happens, you will have to wait six months to apply again for HIP.

**How the POWER Account pays claims for your health care services**
Part of the money you contribute to your POWER account will be used to pay each medical claim for the first $2,500 of your medical bills. If your annual health care costs are more than $2,500 and you use your POWER account entirely, additional covered health services over $2,500 are fully covered at no additional cost to you (unless you are in the HIP Basic program and are responsible for any copayments). Preventive services are not charged to your POWER Account. We want you to enjoy the best health possible. Please get your preventive services every year.

If you are in the HIP Basic plan and you get your required preventive service(s), you will receive credit for the percentage of money you have left in your POWER Account. You can use the credit to reduce the contribution cost by up to 50 percent if you wish to move to the HIP Plus plan.

If you are in the HIP Plus plan, you will receive credit for the portion of unused POWER Account funds that you contributed. If you had your required preventive services, we will double the amount of your credit. The credit will be determined four months into your next benefit period. The credit will reduce your required POWER Account contributions for that period.

**Preventive health care services**
Your POWER Account is not charged for preventive services. We don’t decide how often you get preventive services or age limits. This allows doctors to order the preventive care and services that are right for you.

We encourage you to see your primary care physician for preventive services that are recommended for you.

Preventive service recommendations are based on your age, gender, lifestyle, personal medical history and family medical history.

Preventive care helps you improve your health and not get ill. Please use this benefit and get your preventive care every year. It won’t cost you anything, and it could save your life.
If you are diabetic, these tests are recommended:

- HbA1c
- LDL
- Eye exam and/or kidney function test

It is also strongly recommended that you have a thorough physical exam. Please discuss with your doctor.

If you have a history of coronary heart disease, you should have a thorough physical exam and make sure you have your cholesterol tested.

**POWER Account rollover credit**
You are responsible for managing your entire POWER account, including the money contributed by the state. Your contributions to 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 the HIP program for another year.

**HIP Basic Plan Members:**
If you have money remaining in your POWER account after 12 months and you receive your recommended preventive services, you can enroll in HIP Plus with a reduced monthly POWER account contribution. You can reduce the cost of future enrollment in HIP Plus by up to 50 percent. For example if three quarters (75 percent) of your POWER account remains after 12 months and you receive your recommended preventive services then you can get a 50 percent reduction in the cost of enrolling in HIP Plus.

Since it can take up to four months for your doctors and your health plan to settle all payments from the POWER account, these reductions will be available to you in month five (5) of your next twelve (12) month HIP enrollment period. This means that if you qualify, you will be given a chance to enroll in HIP Plus at that time.

**HIP Plus Plan Members:**
If you have money left over in your POWER account after 12 months, then the amount of your monthly POWER account contribution can be reduced in the future. For example, if half (50 percent) of your POWER account remains after 12 months, then you can get a 50 percent reduction in your required contribution in the future. If you complete the preventive services recommended for you by your health plan, then the reduction to your required contribution is doubled.

For example, if half (50 percent) of your POWER account remains after 12 months and you receive your recommended preventive services, you could eliminate your required contribution.

Since it can take up to four months for your doctors and your health plan to settle all payments from the POWER account, these reductions will be available to you in the fifth month of your next 12-month period of HIP enrollment.
Required preventive services for HIP rollover credit
Qualifying preventive services are those that are defined by the Affordable Care Act (ACA). ACA defines preventive care services as follows:
- Items or services recommended with an A or B rating by the U.S. Preventive Services Task Force
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration
- Preventive care and screenings for women supported by the Health Resources and Services Administration per the August 1, 2011, guidance:
  - Well-woman visits
  - Screening for gestational diabetes
  - Human papillomavirus (HPV) DNA testing
  - Counseling for sexually transmitted infections
  - Counseling and screening for human immunodeficiency virus
  - Contraceptive methods and counseling
  - Breastfeeding support, supplies and counseling
  - Screening and counseling for interpersonal and domestic violence

A listing of the ACA recommendations and guidelines can be found online at www.healthcare.gov/center/regulations/prevention.html.

POWER Account statements
Your POWER Account statement will show the services paid from your POWER Account and the remaining funds in your POWER Account. You will get a statement every month by mail. You can also download electronic copies of your HIP POWER Account statement by signing on to www.anthem.com/inmedicaid.

HIP caretakers have a 5 percent cost-sharing limit
You should not pay more than 5 percent of your household’s income along with what you pay to your POWER Account and any copays. HIP members’ health care expenses are limited to 5 percent of their family income each benefit quarter. Anthem will be tracking your contributions. If we confirm that you have met your 5 percent maximum expense limit for the quarter, you will have no further POWER Account contributions or copayments for the remainder of the quarter. Your costs will be reinstated at the beginning of the following quarter as normal.

However, if you feel that you have paid more than 5 percent of your family’s income for the quarter on healthcare, please contact us immediately at our Customer Care Center toll free at 1-866-408-6131 (TTY 1-866-408-7188). You will need to show written proof of the amount you paid. If we find that you paid a total of 5 percent of your household income, you won’t have to pay any monthly contributions or copays for three months.
**If your income or family size changes**
During your HIP enrollment period, you are required to report changes in your circumstances. You must report the following changes in your circumstances 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. You can continue to receive HIP benefits while pregnant, but you will not have to pay for any costs to receive HIP benefits while pregnant. We also need to know when you deliver your baby or when your pregnancy ends.
- You become insured under Medicare.
- Any other change that you think may affect your eligibility or benefits for HIP.

If you have a change to report, please call or fax information to the FSSA Document Center at 1-800-403-0864, mail to FSSA Document Center, PO Box 1810, Marion, IN 46952 or submit a change request through the FSSA Benefits portal at in.gov/fssa/dfr.

**HIP eligibility and termination**

**HIP Redetermination**
When you enroll in HIP, you are eligible for 12 months. Seventy-five days before the end of your 12-month enrollment period the state will begin a process to see if you are still eligible for HIP. If there is not enough information available to the state to determine if you remain eligible for HIP, you will receive a request for additional information. You must complete and return the requested information to remain eligible. Members in the HIP Basic plan will have the opportunity to change to the HIP Plus plan by paying the required monthly contribution.

**HIP Redetermination during Pregnancy**
If your redetermination comes during a pregnancy, you will remain covered under HIP. However, you will complete your pregnancy under HIP Maternity benefits. You will have the same benefits as all pregnant members. However, your pharmacy and dental benefits under HIP Maternity are handled by the State.

While covered under HIP Maternity, you will not be responsible for any copayments when you receive health care services. These copayments will be suspended for the remainder of your pregnancy.

At the completion of your pregnancy, you will be given an additional 60 days of postpartum coverage without any copayments or required contributions.

However, you must report the end of your pregnancy to the Division of Family Resources (DFR) as soon as possible so that, upon the end of your postpartum period, your regular HIP benefits may be started again. If you do not, you may face a gap in coverage at the end of your postpartum coverage, or your coverage may be terminated and you may need to reapply.
Actions to take when your pregnancy ends:

- Report the end of your pregnancy to the Family and Social Services Administration by calling 1-800-403-0864 within ten (10) days after the pregnancy ends;
- Make your required POWER account contribution prior to the end of the postpartum period;
- Once re-enrolled in HIP Plus, resume making your monthly POWER account contributions.

If you do not take the above actions, you may face a gap in coverage at the end of your postpartum coverage or your coverage may be terminated, and you may need to reapply.

HIP members moving to disability or Medicare coverage

During your HIP membership, you may become eligible for Medicare. 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. Please call 1-877-438-4479 (1-877-GET-HIP) or visit www.in.gov/fssa to learn more about disability or other assistance programs that may meet your needs.

HIP POWER Account/Explanation of Benefits (EOB) statement

In the HIP program, the first $2,500 of medical expenses for covered services are paid with a special savings account called a Personal Wellness and Responsibility (POWER) account. The state will contribute most of this amount, but you will also be responsible for making a small contribution to your account each month. The amount of your contribution amount is based on your income. Members in the HIP Basic plan, do not make monthly contributions, but they pay copayments each time they have a service.

You will receive a POWER Account statement every month which will serve as your explanation of benefits. You can also go to www.anthem.com/inmedicaid to view your statement. The POWER Account statement lists all the claims we have paid and the balance in your POWER Account. The POWER Account statements show you which claims were paid from POWER Account funds. Please call us if you have any questions about your statements.

The EOB is a summary of the health care services your received. It’s not a bill. It’s a statement from us to help you understand the coverage you are getting.
Part 2 – What Anthem covers and does not cover

Anthem provides benefits for our Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) members. HHW includes four different benefit packages. These are called:

- Package A
- Package C
- Package P
- HIP Maternity

HIP has four different plans. They are called:

- HIP Hospital Presumptive Eligibility (HPE)
- HIP Basic
- HIP Plus
- HIP State Plan Benefit

**Hoosier Healthwise (HHW)**

**HHW Package A** is for children and pregnant women.

**HHW Package C** is for preventive, primary and acute care services for children under 19 years of age who don’t qualify for Package A.

**HHW Package P** is for women who are found to be Presumptively Eligible (PE) for Medicaid. To qualify for HHW Pregnancy PE status, you must:

- Be pregnant, as verified by a pregnancy test done by a health care professional.
- Be an Indiana resident.
- Be a U.S. citizen or qualified noncitizen.
- Not be a current Hoosier Healthwise member.
- Not be in prison.
- Have a gross family income less than 200 percent of the federal poverty level.

Package P excludes inpatient services (but if medically necessary, these can be paid after the fact once the woman is certified as a HHW member).

You need an OK ahead of time from your PMP and/or us for some covered services. Anthem will pay only for covered services that are medically necessary. Use a provider in your Anthem network. If you are out of town and need help with an OK for medical care, call our Customer Care Center toll free at 1-866-408-6131 (TTY 1-866-408-7188).

If you have any questions about what is covered or how coverage decisions are made, call our Customer Care Center. If you call after business hours, you may leave a message with the answering service.

**HIP Maternity Plan** is provided under the Hoosier Healthwise benefit if you qualify for HIP and you are already pregnant when you enrolled or re-enrolled. HIP Maternity Plan only continues through two months postpartum. You should apply for regular HIP as soon as you begin your postpartum period.
Healthy Indiana Plan (HIP)

HIP Plus
HIP Plus provides MORE benefits including vision and dental services. HIP Plus gives more visits for physical, speech and occupational therapists than the HIP Basic program, and coverage for additional services like bariatric surgery and Temporomandibular Joint Disorders (TMJ) treatments are included. With HIP Plus, you can get 90-day refills on prescriptions you take every day and receive medication by mail order. You will also receive medication therapy management services that are designed to work closely with your doctors and pharmacies to provide additional assurances that your prescription therapies are safe and effective.

HIP Basic
HIP Basic provides coverage for minimum services but does not cover everything that Plus covers. HIP Basic does not provide coverage for vision or dental services, bariatric surgery or Temporomandibular Joint Disorders (TMJ). HIP Basic benefits also allow for fewer visits to physical, speech and occupational therapists. Unlike HIP Plus, HIP Basic has more limited options for getting medication and you are limited to a 30 day supply and cannot have mail order medications delivered. HIP Basic also does not provide medication therapy management services that are designed to work closely with your doctors and pharmacies to provide additional assurances that your prescription therapies are safe and effective. These services are only available in HIP Plus through paying your POWER account contribution.

HIP State Plan Benefits
HIP State Plan Benefits include some additional benefits for qualified members. State Plan Benefits are made available to members who qualify in the low income caretaker category. State Plan Benefits are also available to members who qualify in the Medically Frail category.

Members who receive State Plan Benefits are still enrolled in either the HIP Plus plan, or the HIP Basic plan. The benefits are the same for members with State Plan Benefits in either the HIP Plus plan and HIP Basic plan. However, members in the HIP Plus plan pay monthly contributions so their cost is predictable. Members in the HIP Basic plan must pay copayments when they have services. The HIP Basic plan can be much more costly than the HIP Plus plan due to the required copayments. And, the costs are not predictable like they are with monthly payments. HIP State Plan Benefits are the same as the benefits under Hoosier Healthwise.

Medically Frail: Individuals with certain complex medical or behavioral health conditions can qualify for State Plan Benefits under their HIP plan.

An individual may qualify for the HIP medically frail category if he or she has been determined to have one or more of the following:
- Disabling mental disorder;
- Chronic substance abuse disorder;
- Serious and complex medical condition;
- Physical, intellectual or developmental disability that significantly impairs the individual’s ability to perform one or more activities of daily living; or
- Disability determination from the Social Security Administration.
If you told us on your initial application that you had a medical condition that qualifies you in the Medically Frail category, we need to speak to you to confirm that you qualify. You will receive State Plan benefits for the first 60 days based on your application. We must speak to you and your doctor to verify that your condition qualifies for the increased benefits. If we are unable to verify the condition, your benefits will be changed to regular HIP benefits. You will receive a letter to inform you of the change.

Please help us confirm your health condition. You should complete your health assessment right away. You should also tell us everything you can about your health. Please call us if you have questions or have not talked to us in the first month of your coverage.

Members in regular HIP plans may also contact us to report a medical condition that may qualify them for benefits under the Medically Frail category. Anthem may also request information based on claim information or responses to health needs assessments and surveys.

When a member is verified as having a medical condition that qualifies them for the Medically Frail category, we won’t need to confirm this again for one year. State Plan benefits are the same benefits that are provided to Hoosier Healthwise (HHW) members (see the section below for details). However, dental, vision and pharmacy benefits are not carved out. They are provided through Anthem for HIP members.

Anthem covered services for members in Hoosier Healthwise (HHW), HIP Maternity, HIP Basic plan with State Plan benefits and HIP Plus plan with State Plan benefits

**Doctor care:**
- Preventive care
- Physical exams
- Prenatal care
- Well-child checkups
- Immunizations
- Specialty care
- Chiropractic services
  - For Package A, HIP Maternity and HIP State Plans: up to five visits per year and up to 50 therapeutic physical medicine treatments per year
  - For Package C, up to five visits per year and up to 14 therapeutic physical medicine treatments in a rolling 12-month period

**Note:** Members in the HIP Basic plan must pay $4 copayment for each service that is not preventive or family planning. Since copayments are per service, multiple copayments may be charged for one visit.

**Hospital care:**
- Emergency room
  - HIP Basic and HIP Plus plan members pay a copayment if not a true emergency. The first time the copayment is $8 and each additional is $25.
• Inpatient services
  – HIP Basic plan members pay $75 copayment
• Outpatient services and surgeries
  – HIP Basic plan members pay $4 for each service
• Lab tests and X-rays
  – HIP Basic plan members pay $4 for each outpatient service
• Post-stabilization services
• Ambulance transportation for emergencies
  – Package C requires $10 copay for ambulance transport
  – HIP Basic plan members pay $4 copay for covered ambulance transport

Medical supplies:
• Diabetes supplies
  – HIP Basic plan members pay $4 copay for each covered service
• Durable medical equipment
  – For Package C, annual maximum benefit is $2,000 per year and lifetime maximum benefit is $5,000
  – HIP Basic plan members pay $4 copay for each covered service
• Hearing aids
  – HIP Basic plan members pay $4 copay
• Orthopedic shoes and leg braces
  – HIP Basic plan members pay $4 copay
• Orthotics and prosthetic devices
  – HIP Basic plan members pay $4 copay

Other benefits:
• Authorized therapies (physical, speech, occupational and respiratory therapy)
  – For Package C, maximum of 50 visits for each therapy type per rolling 12-month period
  – HIP Basic plan members pay $4 copay per service
• Behavioral health care for mental health and substance abuse
  – HIP Basic plan members pay $4 copay per service
• Smoking cessation — one 12-week course of treatment per calendar year
• Skilled nursing facility
  – For Package A and HIP Maternity – up to 60 days per rolling 12-month period
  – For HIP Basic and HIP Plus plans – up to 100 days per rolling 12 month period
  – HIP Basic plan members pay $75 copay per admission
  – For Package C, not covered
• Renal dialysis
  – HIP Basic members pay $4 copay per service
• Vision services for Package A and HIP Maternity
  – One exam every 12 months
  – Glasses every five years
  – Contact lenses, if medically necessary
• Vision services for HIP Basic and HIP Plus plan
  – One exam every 12 months
  – Glasses every 2 years
  – Contact lenses if medically necessary
• Vision services for Package C
  – Glasses every year, contacts if medically necessary
• Podiatry services
  – For Package A, HIP Maternity and HIP State Benefits: up to six routine foot care visits per year
  – HIP Basic plan members pay $4 copay
  – For Package C, routine foot care is not covered
• Home health care
  – HIP Basic plan members pay $4 copay
• Nurse practitioner services
  – HIP Basic plan members pay $4 copay per service (except preventive or family planning)
• Nonemergency transportation: Package A, HIP Maternity and HIP State Plans: Unlimited trips and Anthem also allows trips:
  – For those enrolled in the Women, Infants, and Children (WIC) program
  – To the Division of Family Resources (DFR)
  – To health education programs
  – Package C allows up to 20 one way trips of up to 50 miles each.

Self-Referral Services
You can receive self-referral services without seeing your PMP to get a referral. You can see any Indiana Medicaid provider. Remember to talk to your PMP about all your health care needs:
• Behavioral health
• Chiropractic care
• Diabetes self-care training
• Emergency services
• Eye and vision care
• Family planning
• HIV/AIDS care management
• Podiatry services
• Immunizations

Some services are covered by the State for HHW and HIP Maternity members (not by Anthem)
Indiana Medicaid covers some types of care for HHW members. These types of service are called “carve-outs.” You may get these services from any IHCP-enrolled provider. If you have questions about carved out services, you can call our Customer Care Center toll free at 1-866-408-6131 (TTY 1-866-408-7188), Monday through Friday from 8 a.m. to 8 p.m.
HHW and HIP Maternity carve-out services include:
- Dental
- Pharmacy/Prescriptions
- Medicaid Rehabilitation Option (MRO) – Also carved out for HIP State Plan Benefits
- Hospice (HHW members who need hospice services must disenroll from Anthem HHW and enroll in traditional Medicaid)

Note: HIP members who receive State Plan benefits have the same benefits as HHW members. However, Pharmacy, Dental and Hospice services are not carved out. These benefits are provided through Anthem for HIP members.

**Services not covered by Anthem:**
- Services that are not medically necessary
- Nursing home (for more than allowed under Plan benefits) or long-term care facility services
- Intermediate Care Facility Services (ICF/MR)
- Services under the Home- and Community-based Services (HCBS) waiver
- Psychiatric state hospital or residential treatments
- Services/Care you receive in another country
- Acupuncture
- Experimental or investigational treatments
- Cosmetic surgery
- Alternative medicine
- Surgery or drugs to help you get pregnant
- Sex change surgery or treatments
- Cosmetic surgery (this does not apply to reconstructive surgery)
- Vitamins, supplements and over-the-counter medicines not covered through the pharmacy benefit
- Over-the-counter birth control
- Private duty nursing
- For any condition, disease, defect, ailment or injury that takes place while working if you have workers’ compensation

**Anthem covered services for Healthy Indiana Plan (HIP) members**

**HIP Basic Plans:** Copays are required when members in the HIP Basic Plans have services.
- Inpatient: $75
- Outpatient/Office visits: $4
- Preferred drugs: $4
- Nonpreferred drugs: $8
- Nonemergency ER Visit: $8 for the first visit and $25 for additional visits in the same benefit year. Members are not charged if they call the 24/7 NurseLine at 1-866-800-8780 before going to the ER.

Pregnant members are not required to pay copays. Copays are also waived for anyone who has paid a total of 5 percent of their income for medical services already during the past quarter.
**HIP Plus Plans:** HIP Plus is the preferred plan for all HIP members. HIP Plus provides the best value coverage and includes vision and dental services. In HIP Plus, members pay affordable monthly contributions based on income and do not pay any other costs or copayments unless they visit the emergency room when they don’t have an emergency health condition. Services include:

- Vision services
- Dental services
- Bariatric (weight loss) surgery
- Treatment for temporomandibular joint disorder (TMJ, a jaw disorder)
- More therapy sessions for conditions requiring physical, speech, occupational, respiratory and/or cardiac therapy

HIP Plus members who qualify for State Plan benefits receive the same benefits as HHW members.

**HIP Plus Plan members do not pay anything when they get covered services, except for services at a hospital emergency room if your condition was not a true emergency.** You will be charged $8 the first time, and $25 each additional time in the same benefit year. You won’t be charged if you call the 24/7 NurseLine at 1-866-800-8780 before you go to the ER.

Other members who do not have to pay a copay include:

- Pregnant members
- Anyone who has paid a total of 5 percent of their income for medical services already during the past quarter

**HIP Benefits** (See the HHW section if you are enrolled in HIP with State Plan benefits.)

**Note:** HIP Basic plan members must pay copayments as stated above, unless services are preventive or for family planning. Pregnant members are not required to pay copayments. Covered services for members in HIP Basic and HIP Plus plans:

**Doctor care:**

- Preventive care
- Physical exams
- Immunizations
- Specialty care

**Hospital care:**

- Emergency room
- Inpatient services
- Outpatient services and surgeries — bariatric (weight-loss) surgery is covered under HIP Plus
- Lab tests and X-rays
- Post-stabilization services
- Ambulance transportation for emergencies
Medical supplies:
- Diabetes supplies
- Durable medical equipment
- Hearing aids
- Orthotics and prosthetic devices

Other benefits:
- Physical, speech, occupational, respiratory, cardiac therapy
  - HIP Basic allows up to 60 treatments for each episode per benefit period.
  - HIP Plus allows up to 75 treatments for each episode.
  - There is no limit under State Plan benefits.
- Behavioral health care for mental health and substance abuse
- Smoking cessation
- Renal dialysis
- Podiatry services for diabetic care
- Home health care
- Skilled nursing in a nursing facility up to 100 days
- Hospice care
- Temporomandibular joint disorder (TMJ, a jaw disorder) covered under HIP Plus
- Nurse practitioner services
- Nonemergency transportation
  - HIP Basic and Plus Plans allow up to 20 one-way trips (an added value benefit that Anthem provides to HIP Basic and HIP Plus members).
- Vision: covered for HIP Plus members, pregnant members, and members in HIP Basic Plans ages 19 and 20.
  - Coverage includes one vision exam per year
  - Glasses (or contacts when medically necessary) every two years
- Dental: covered for HIP Plus members, pregnant members, and members in HIP Basic Plans ages 19 and 20.
  - Two exams and cleanings and four bitewing x-rays per year
  - Extractions and up to four basic restorations such as fillings, and one crown per year

You can receive these self-referral services without seeing your PMP to get a referral. Remember to talk to your PMP about all your health care needs:
- Behavioral health — you can go to any Indiana Medicaid provider
- Diabetes self-care training — you can go to any Anthem HIP provider
- Emergency services
- Family planning — you can go to any Indiana Medicaid provider
- Immunizations — you can go to any Anthem HIP provider

Services not covered by Anthem HIP:
- Services that are not medically necessary
- Nursing home (other than short-term) or long-term care facility services
- Acupuncture

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• Experimental or investigational procedures
• Care you get in another country
• Surgery or drugs to help you get pregnant
• Sex change surgery or treatments
• Cosmetic surgery (this does not apply to reconstructive surgery)
• Psychiatric state hospital or residential treatment
• Chiropractic spinal manipulations, except for pregnant members
• Vitamins, supplements and over-the-counter medicines, which are not covered under your pharmacy benefit
• Over-the-counter birth control, except as provided by family planning providers
• For any condition, disease, defect, ailment or injury that takes place while working if you have workers’ compensation
• Private duty nursing
• The evaluation or treatment of learning disabilities
Part 3 – How to fill your prescriptions

HHW members (Including HIP Maternity members)
Your pharmacy benefit is handled by Indiana Medicaid through a company called Catamaran.

HIP members (Including HIP State Plan members)
Your pharmacy benefit is handled by Anthem through a company called Express Scripts.

How your pharmacy benefit works
When you need drugs or certain prescribed over-the-counter (OTC) items, your doctor will write you a prescription. Your doctor will then call your pharmacy, or you can take the prescription to your pharmacy to get your drugs.

HHW members must use a pharmacy that takes Indiana Medicaid (this may include mail order pharmacies). To find a pharmacy that takes Indiana Medicaid, you may ask your local pharmacy or call Catamaran Member Services at 1-855-577-6317 and press option 3 for Benefits. Or go to: http://indianamedicaid.com/ihcp/ProviderServices/ProviderSearch.aspx.

HIP members must use a pharmacy that participates in the Anthem HIP Pharmacy Provider Network. Anthem contracts with Express Scripts to manage HIP pharmacy benefits. Express Scripts works with pharmacies that are contracted with Indiana Medicaid.

Note: Always show your ID card to your pharmacy provider.

Your pharmacy benefit has a Preferred Drug List (PDL). The PDL shows some of the drugs covered under the pharmacy benefit. A team of doctors and pharmacists updates this list four times a year. Updating this list ensures that the drugs are safe and useful for you. Drugs in classes on the PDL are either preferred or nonpreferred. Preferred drugs usually do not need an OK ahead of time. As a rule, nonpreferred drugs need an OK ahead of time.

If you don’t see a drug listed in our noncovered services list, the drug can be covered by the Indiana Medicaid program. The PDL has details about:
- Names of preferred and nonpreferred drugs.
- Limits on the amount of a drug you may get.


HIP members can find the PDLs at www.anthem.com/inmedicaid.

Note: There are three HIP PDLs: HIP Basic, HIP Plus and HIP State Plan benefits. Each of them are different. You will find that the PDL for HIP State Plan benefits are the same as the HHW PDL.

Prescription drugs and items approved by the U.S. Food and Drug Administration (FDA) may be covered by your pharmacy benefits.
These prescription drugs are not covered:
- Over-the-counter (OTC) medicines (unless specified on formulary or PDL list)
- Drugs used to get pregnant
- Experimental or investigational drugs
- Drugs for cosmetic reasons
- Drugs for weight loss
- Drugs for hair growth
- Drugs to treat erectile dysfunction

**Generic drugs**
Your pharmacist will give you generic drugs when your doctor has approved them. Generic drugs are as good as brand-name drugs. Generic substitution under the program is required by law. The PDL will tell you the exceptions to this requirement. Generic drugs must be given when there is one. Brand-name drugs may be given if there is not a generic drug for it. Generic and preferred drugs must be used when offered for your medical condition, unless your doctor gives a medical reason that you must use a different drug.

**Over-the-counter (OTC) Drug Formulary**
Some OTC drugs are covered by your PDL. Only the OTC drugs that are listed may be covered, and they are only covered when prescribed by your physician.

**Prior authorization for drugs**
You may need a drug that needs an OK ahead of time. In this case, your doctor will need to give details about your health, and then we will decide whether or not Indiana Medicaid can pay for the drug. This is important for these reasons:
- You may need tests or help with a drug.
- You may be able to take a different drug.

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

HHW members: Prior authorization for prescriptions is requested from Indiana Medicaid.

HIP members: Prior authorization for prescriptions is requested from Anthem. See your ID card for the telephone number. Indiana Medicaid or Anthem will decide if your drug request can be approved within 24 hours after getting your request (not including Sundays or some holidays). Your doctor will be told.

**Your appeal rights**
If your drug request is denied, you or your provider can appeal this decision.
**Medicaid hearing and appeal process**
If you do not agree with the appeal decision, you may ask for a Medicaid hearing and appeal review. You may ask for a Medicaid hearing and appeal review if Indiana Medicaid or Anthem:
- Denied you a service
- Reduced a service
- Ended a service that was approved before
- Failed to give you timely service

To ask for a review, you must send a letter to the Medicaid agency within 30 business days of getting our decision about your appeal. Send your letter to:

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

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

**Days’ supply of drugs**
Drugs you take for a long time (often called maintenance drugs) have a 100-day supply limit. While drugs you take for a shorter time (known as nonmaintenance drugs) have a 34-day supply limit. Maintenance drugs are taken for illnesses such as asthma, diabetes and high blood pressure. As a rule, nonmaintenance drugs are taken for short-term illnesses such as colds, the flu, and body aches and pains.

**Early refill**
Your pharmacist will have to ask for an OK ahead of time if you want to get your prescription refilled early. But do not wait until you are 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.

**Pharmacy copays**
Hoosier Healthwise members who get benefits under Package A may have to pay $3 for each drug. Hoosier Healthwise members who get benefits under Package C may have to pay $3 for generic drugs and $10 for brand-name drugs. This amount is called a copay. But there are times when you do not have a copay, such as:
- Services for members under 18 years of age.
- Services that have to do with pregnancy.
- Services that have to do with family planning (birth control and preventive supplies).
- Services you get in the ER or a nursing home.
- Services while in a hospital.

Women who are Presumptively Eligible due to pregnancy will not have a copay for their drugs.

Women in the HIP Maternity Plan do not have to pay a copay. There will be no copay for any drug given as an emergency supply.
HIP members in the Basic Plan will need to pay $4 for preferred drugs and $8 for nonpreferred drugs. Pregnant HIP members will not be required to pay any copays. HIP members who have spent 5 percent of their income for copays, premiums and/or contributions, will also be exempt from paying any copays.

HIP members in the Plus Plan do not pay copays for pharmacy services.

HHW members should call the Indiana Medicaid Pharmacy Member Services Hotline at 1-800-457-4584 between 8 a.m. and 6 p.m. Monday through Friday.

HIP members should call Anthem Member Services for pharmacy questions at 1-866-408-6131 (TTY 1-866-408-7188).

HIP POWER Accounts (for HIP members)

All covered drug expenses apply to the deductible and will be paid from your POWER Account until the deductible is met.
Part 4 – Programs to help keep you well

Each person has special needs at every stage of life. Whether you are a man or a woman, a child or an adult, we have programs to help you stay healthy and manage illness. For members of the Anthem health plan, these programs are at no cost to you. We hope you and your family use them. We want you to be well and to stay that way.

For women

• Well-woman care includes information about healthy behaviors and the need for regular exams, mammograms and cervical cancer screenings.
• Family planning can help teach you:
  – How to be as healthy as you can before you get pregnant.
  – How to prevent pregnancy.
  – How to prevent sexually transmitted infections (STIs) such as HIV/AIDS.
• Pregnancy and childbirth classes give you knowledge to help you stay healthy while you’re pregnant.
• Our prenatal program, Future Moms, provides educational materials to help you have a healthy pregnancy. Plus, you get a reward when you see your doctor 21 to 56 days after your baby is born.
• 24/7 NurseLine, the toll-free, 24-hour nurse help line, provides breastfeeding support for moms-to-be and new mothers who have questions about how to breastfeed. A registered nurse will answer your questions and get you the support you need to breastfeed your baby. Call the toll-free 24/7 NurseLine phone number at 1-866-800-8780 (TTY 1-800-368-4424).

For you and your child

• Well-child care includes programs to help you keep your child well. You can learn about healthy habits for your child, the need for regular doctor visits and which vaccines your child needs.
• We offer parenting tips to teach you how to care for your child.

For your peace of mind

• 24/7 NurseLine, the toll-free, 24-hour nurse help line, lets you talk in private with a registered nurse (RN) about your health. Teens also can talk to RNs in private about teen issues. Just call the 24/7 NurseLine at 1-866-800-8780 (TTY 1-800-368-4424). By calling the 24/7 NurseLine, you also can access audiotapes on 400 health topics, such as:
  – Preventive health care guidelines to help you and your family see the doctor at the right times.
  – High blood pressure.
  – Diabetes.
  – Sexually transmitted infections such as HIV/AIDS.
  – Alcohol and drug problems.
  – How to be tobacco-free.
  – Pregnancy.
When HIP members call the Anthem NurseLine, they will not be charged a copay if the hospital determines the visit isn’t an emergency.

**How to get other services**
You can get help from a special program called **Women, Infants, and Children (WIC)**. The WIC program gives healthy food to pregnant women and mothers of young children. WIC also will give you free news about foods that are good for you. If you have questions about this program, call **1-800-522-0874**.

As an added value benefit, Anthem provides HHW Package A, HIP Maternity and HIP State Plan members with free transportation to WIC locations.

You may want care or services that are not covered by Anthem. Call our Customer Care Center toll free at 1-866-408-6131 (TTY 1-866-408-7188) if you think that other programs or services can help you.
Part 5 – Help with special services

Help in other languages
Anthem offers services and programs that meet many language and cultural needs and help give you access to quality care. We use an interpreter service that works with more than 140 languages. We want you to have access to the right services, so we offer:

- Health education materials translated into different languages.
- Customer Care Center staff able to speak other languages.
- 24-hour access to telephone interpreters.
- Sign language and face-to-face interpreters.
- Providers who speak other languages.

If you do not speak English and need an oral interpreter during your medical visit, you can ask for a face-to-face or phone interpreter free of charge to you. Call us at least 72 hours in advance at our toll-free Customer Care Center at 1-866-408-6131 (TTY 1-866-408-7188). We are open Monday through Friday from 8 a.m. to 8 p.m. We will get someone who speaks your language to help you. We also can translate for you while you are at your PMP’s office. Ask your PMP to call us at least 72 hours in advance. We will be glad to help. You do not have to pay for this service.

Help for members with hearing or vision loss
Call our toll-free Customer Care Center (CCC) at 1-866-408-6131 (TTY 1-866-408-7188). The CCC is open Monday through Friday from 8 a.m. to 8 p.m. If you need help between 8 p.m. and 7 a.m. and on weekends, call Relay Indiana at 1-800-743-3333 (TTY 711).

This handbook and other plan materials, including letters, newsletters and health education information, are offered in other formats for members with hearing or vision loss. To get this handbook and other plan materials in other formats such as Braille, large print or audio CD, call our Customer Care Center. You can also call us if you need help reading this book or other materials.

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 our toll-free Customer Care Center or CCC TTY number.
Part 6 – How to resolve a problem with Anthem

We care about the quality of care that you get from us and your health care providers. If you have a concern, we would like to talk with you. Call us at our Customer Care Center 1-866-408-6131 (TTY 1-866-408-7188).

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 problem (inquiry)

We want to help. If you are not happy with the care you get from one of your network providers, please let us know. There are two ways you, or someone you choose to act for you, can let us know your problem:

- Call us toll free at 1-866-408-6131 (TTY 1-866-408-7188).
- Send us a letter. Our address is:

  Anthem Blue Cross and Blue Shield
  P.O. Box 6144
  Indianapolis, IN 46206-6144

Our Customer Care Center 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.

If a decision about your problem cannot be made within one business day, it becomes a complaint.

Grievances

You, or the person you choose to act for you, can file a grievance 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 PMP first. If you still have questions or concerns, call us. We can help you. You will not be treated differently for filing a grievance.

If your problem has to do with a denial of your health care benefits, you need to file an appeal instead of a grievance. Please see the part called Appeals later in this chapter.

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.
Or if you have a seeing or speaking problem, we can help you with your grievance process. Please call our toll-free CCC TTY phone number below. Most of the time we can help you right away or within a few days. You have three ways to file a grievance with us. You can:

- Call our toll-free Customer Care Center at **1-866-408-6131** or CCC TTY number at **1-866-408-7188** (for those with hearing or speech loss).
- Complete a grievance form found on our website www.anthem.com/inmedicaid.
- Write us a letter to tell us about the problem.

You can also find grievance forms where you get care, such as your PMP’s office.

Here 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 are not happy

Attach any documents that will help us look into the problem.

Send your completed form or letter to:

**Attn: Grievance Department**

**Anthem Blue Cross and Blue Shield**

**P.O. Box 6144**

**Indianapolis, IN 46206-6144**

If you cannot mail the form or letter, you or the person you choose to act for you, may call our toll-free Customer Care Center at 1-866-408-6131 or CCC TTY number at 1-866-408-7188. We will send you an acknowledgment letter within **three business days**.

If we cannot make a decision about your grievance within **20 business days**, we can ask the state agency to give us extra time (up to **10 business days**). If we do this, we will send you a letter to tell you why we need more time.

**Expedited (rush) grievance**

You may ask us to handle your grievance faster if your health needs it. We answer problems that need to be taken care of right away within **48 hours**. We will call you or send you a letter with our decision within **48 hours** after we get your expedited grievance. The letter will let you know about our decision.

**Appeals**

If you want to file an appeal about how we solved your problem, you or someone you choose to act for you, can ask for an appeal within **30 calendar days** from the day of our decision on the grievance resolution letter.
Send your appeal to:
Attn: Appeal Department
Anthem Blue Cross and Blue Shield
P.O. Box 6144
Indianapolis, IN 46206-6144

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

You can also ask for an appeal by calling the Customer Care Center at 1-866-408-6131 (TTY 1-866-408-7188). You must ask for an appeal in writing after you ask for one over the phone, unless you ask for a rush appeal.

We will make a decision about your appeal within 20 business days after we get it. If we cannot decide within 20 business days, we can ask the state agency to give us more time (up to 10 calendar days). If we do this, we will send you a letter to tell you why we need more time.

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

**Expedited (rush) appeal**
You may ask us to rush your appeal if your health needs it. We will let you know we got your appeal within 24 hours from the time we received it. We will make a decision and send you a letter within 48 hours to let you know.

If we say “no” to your request for a rush appeal, we will call you. We also will send you a letter with the reason for the delay within two calendar days.

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

**External independent review**
We have a special process called an “external independent review” (EIR). This process provides a neutral review of coverage decisions made by Anthem.

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

You or the person you choose to act for you must file a written request for this special process.
This must be filed within **45 calendar days** from the date we told you that your appeal had been denied.

Within **three business days** after we get your request, we will send you a letter to say that we got it.

External independent reviews (EIRs) are resolved within **15 business days** from the date of request. We will send you a letter with the answer within **72 hours** from when we decided. The letter will explain:

- Your right to ask for a Medicaid hearing.
- How to ask for a hearing.
- Your right to keep your benefits until the hearing is over.
- That you may have to pay the costs for services that you are 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. We will take care of your request as fast as we can, but no more than **72 hours** from the time we get your appeal. We will send you a letter within **24 hours** after we reach a decision.

**Medicaid hearing and appeal process**
If you have a problem with what we decide after completing our appeal process, you can ask for a Medicaid hearing and appeal review. You may ask for this review if we:

- Said “no” to paying for a service you wanted.
- Said “OK” to a service, but then we put limits on it.
- Ended payment for a service that we said “OK” to before.
- Did not give you access to a service fast enough.

To ask for a review, you must send a letter to the state Medicaid agency within **30 business days** of getting our decision about your appeal. Send your request to:

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

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

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

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

If you are not happy with what the agency decides, you may file for a judicial review.
If we no longer can serve you
Sometimes Anthem cannot serve you anymore. We cannot keep you as a member of the health plan if you:
- Lose your eligibility.
- Are disenrolled from (no longer a member of) the HHW or HIP program.
- Move out of Indiana.
- Were signed up in error.
- Become eligible for Medicare.
- Are on HIP and become covered under other health insurance.

You can disenroll from HHW or HIP at any time. If you want to continue with your health coverage, but disenroll from Anthem, there are certain rules.
Part 7 – Other things you may need to know

You may have questions that have not yet been answered in this handbook. Look through this section for the answers.

Our Customer Care Center staff can tell you about these:

- Eligibility
- Benefits
- How to get services
- Health education
- How to choose or change your PMP
- Health plan information
- How to get a written copy of our privacy policies and procedures
- Help with transport
- Complaints and appeals

If you have other insurance

Please call our Customer Care Center at 1-866-408-6131 (TTY 1-866-408-7188) if you or your children have other health insurance. Please tell us if you are covered by another health insurance plan. This helps us work with your other insurance 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.

Choosing a new health plan

Hoosier Healthwise (HHW) members: You can change to a different HHW health plan for any reason during the first 90 days of your eligibility.

Healthy Indiana Plan (HIP) members: HIP members may change to a different HIP plan for any reason during the first 60 days of health plan membership or until making the first HIP Plus payment.

Later, you may change health plans:

- After you have been with Anthem for 12 months and you are going through redetermination.
- If you’re in Hoosier Healthwise and you are re-enrolled after losing Medicaid eligibility for two months or less.
- If you are in Hoosier Healthwise and, after losing Medicaid, the break in your eligibility has caused you to miss your yearly open enrollment time period. You will get a new 90-day chance to change health plans.
- If your PMP no longer works with Anthem but remains available through another plan, you may request to change plans.
- If Anthem does not give you the care you seek, but it would be available with another health plan.
• If Anthem does not include network providers that know how to deal with your health care needs, and another health plan does.
• If you receive poor quality care as a result of being a member of the Anthem health plan.

If you have a question about changing your health plan, please call the toll-free Customer Care Center at 1-866-408-6131 (TTY 1-866-408-7188).

You also may call the Hoosier Healthwise Helpline at 1-800-889-9949 or the Healthy Indiana Plan Helpline at 1-877-438-4479.

What to do if you get a bill
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 covered 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 our toll-free Customer Care Center. Have the bill with you when you call and tell us:
• The date of service.
• The amount being charged.
• Why you are being billed.

Sometimes you may get a “statement” from a provider that is not a bill. Call us if you have any questions and we will help you to know if you have to pay the bill.

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

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

Anthem Medicaid Special Investigations Unit
4425 Corporation Lane
Virginia Beach, VA 23462

Phone: 1-877-725-2702 (TTY 1-866-494-8279)

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

Privacy policies
Anthem has the right to get information from those who give you care. We use this information so we can pay for and manage your health care. We keep this information private between you, your health care provider and Anthem, except as the law allows.
Refer to the Notice of Privacy Practices to read about your right to privacy. This notice was included in your Anthem new member packet. If you would like a copy of the notice, please call our toll-free Customer Care Center at 1-866-408-6131 (TTY 1-866-408-7188).

**Your medical records**
Federal and state laws allow you to see your medical records at any time with some exceptions. Ask your PMP for your records first. If you have a problem getting your medical records from your PMP, call our toll-free Customer Care Center at 1-866-408-6131 (TTY 1-866-408-7188).

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

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

You may change or revoke your living will at any time by telling your PMP or other health care provider. You may file a complaint with the state survey and certification agency if you believe your doctor is not meeting the terms of your living will. Ask your family, PMP or someone you can trust to help you. The forms you need are at office supply stores, drugstores or a lawyer’s office. **Call our toll-free Customer Care Center at 1-866-408-6131 (TTY 1-866-408-7188) if you have questions about living wills.**

**Review of member records**
By using the benefits described in this handbook, you agree to allow us, or someone we choose, to look at your medical records for these reasons:
- Utilization review
- Quality assurance
- Peer review

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

Your opinion is very important to us. You will receive a member satisfaction survey each year. Your answers are anonymous. This information is used to improve our services and your care.

**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 will let your doctor know if the treatment is medically necessary and if we approve it.

Anthem is certified by the National Committee for Quality Assurance (NCQA). We have passed a review on quality standards and performance measures. It shows our commitment to quality to you. If you would like more information, you can ask for details about the Anthem QI program. It shows commitment to quality. If you would like more information, you can call our toll-free Customer Care Center at 1-866-408-6131 (TTY 1-866-408-7188).
Part 8 – Your health care rights and responsibilities

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

- To receive information about Anthem, the services Anthem provides, Anthem’s provider network, and your rights and responsibilities. We’ll send you a member handbook and a member newsletter when you enroll and annually. You can also find information about Anthem on our website at www.anthem.com/inmedicaid. You can also call the Customer Care Center toll free at 1-866-408-6131 (TTY 1-866-408-7188).
- 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.
- You have the right to know if your doctor takes part in a physician incentive plan through Anthem. You may call us to learn more about this. Anthem does not give incentives to doctors for not providing care.
- Take part in all decisions about your health care. This includes the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal laws on the use of restraints and seclusions.
- Request and receive a copy of your medical records. And you may request they be amended or corrected, as stated in state and federal health care privacy laws.
- Have timely access to covered services and medically necessary care.
- Have honest talks with your doctors about the right treatment for your condition, in spite of the cost or your benefit coverage.
- 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 fast. (This includes things you think are wrong, as well as issues that have to do with your coverage, payment of services or getting an OK from us.)
- Have access to medical advice from your doctor, either in person or by phone, 24 hours a day, 7 days a week. (This includes emergency or urgent care.)
- Get interpreter services at no charge if you speak a language other than English or if you have hearing, vision or speech loss.
- Ask for information and other Anthem materials (letters, newsletters) in other formats. These include Braille, large-size print or audio CD, at no charge to you. Call the toll-free Customer Care Center at 1-866-408-6131 (TTY 1-866-408-7188).
- Tell us what you would like to change about your health plan.
- Question a decision we make about coverage for care you got from your doctor. (You will not be treated differently if you file a complaint.)
- Ask about our quality program and tell us if you would like to see changes made.
- Ask us how we do utilization review and give us ideas on how to change it.
- Know you will not be held liable if your health plan becomes insolvent (bankrupt and cannot pay its bills).
Know that Anthem, your doctors or your other health care providers cannot treat you differently for these reasons:
- Your age
- Your sex
- Your race
- Your national origin
- Your language needs
- The degree of your illness or health condition

Member responsibilities
As a member of this health plan, you have the responsibility to:
- Tell us, your doctor and your other health care providers what they need to know to treat you.
- Understand your health problems.
- Follow the treatment plans that you, your doctors and your other health care providers agree to.
- Do the things that keep you from getting sick.
- Treat your doctor and other health care providers with respect.
- Make appointments with your doctor when needed.
- Keep all scheduled appointments and be on time.
- Call your doctor if you cannot make it to your appointment.
- Always call your PMP first for all of your medical care (unless you have an emergency).
- Show your ID card each time you get medical care.
- Use the emergency room only for true emergencies.
- Pay any required copays.
- Pay your monthly contribution payment on time (if you are a HIP member who is required to pay something).
- Tell us and your social worker if:
  - You move.
  - You change your phone number.
  - You have any changes to your insurance.
  - The number of people in your household changes.
  - You become pregnant.
# Part 9 – Important Phone Numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone number</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Care Center (Anthem)</td>
<td>1-866-408-6131</td>
<td>Hours: Monday-Friday, 8 a.m. to 8 p.m. Call this number if you have questions about your Anthem health plan. This includes Behavioral Health and Substance Abuse services.</td>
</tr>
<tr>
<td>Customer Care Center (Anthem) TTY*</td>
<td>1-866-408-7188</td>
<td></td>
</tr>
<tr>
<td>HHW: Indiana Medicaid Pharmacy Member Services Hotline</td>
<td>1-800-457-4584</td>
<td>For questions about HHW pharmacy benefits.</td>
</tr>
<tr>
<td>HIP: Pharmacy Member Services Hotline</td>
<td>1-866-408-6131</td>
<td>For questions about HIP pharmacy benefits.</td>
</tr>
<tr>
<td>(TTY 1-866-408-7188)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24/7 NurseLine — toll-free, 24-hour nurse help line</td>
<td>1-866-800-8780</td>
<td>Call this number to talk in private with a nurse. You may call this line 24 hours a day, seven days a week.</td>
</tr>
<tr>
<td>24/7 NurseLine TTY</td>
<td>1-800-368-4424</td>
<td>You also may call this line for an interpreter.</td>
</tr>
<tr>
<td>Transportation</td>
<td>1-800-508-7230</td>
<td>Call this number to schedule nonemergency transportation to medical appointments.</td>
</tr>
<tr>
<td>National Poison Control Center</td>
<td>1-800-222-1222</td>
<td>Call this number to talk with a nurse or doctor. He or she can give you free poison prevention advice and treatment. This toll-free number is open 24 hours a day, seven days a week.</td>
</tr>
<tr>
<td>(Calls are routed to the closest local office.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relay Indiana</td>
<td>1-800-743-3333 or 711</td>
<td>Members with hearing or speech loss may call this number and a trained person will help them speak to someone who uses a standard phone.</td>
</tr>
<tr>
<td>Vision Service Plan (VSP)</td>
<td>1-866-866-5641</td>
<td>Call this number to help find a vision provider. You also can learn more about your vision benefits.*</td>
</tr>
<tr>
<td>VSP TTY</td>
<td>1-800-428-4833</td>
<td></td>
</tr>
<tr>
<td>(Members in the St. Francis Health Network: Please call your primary doctor.)</td>
<td></td>
<td>*Administered by Vision Service Plan (VSP), an independent company that does not provide Blue Cross and/or Blue Shield products.</td>
</tr>
<tr>
<td>Women, Infants, and Children (WIC) program</td>
<td>1-800-522-0874</td>
<td>Call this number to learn more about this program, which gives healthy food to pregnant women and mothers of young children.</td>
</tr>
<tr>
<td>Service</td>
<td>Phone number</td>
<td>Information</td>
</tr>
<tr>
<td>---------------------</td>
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<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>HHW Dental Services</td>
<td>1-800-457-4584</td>
<td>Call this number to find HHW dental providers, or if you have questions about HHW dental services.</td>
</tr>
<tr>
<td>HIP Dental Services</td>
<td>1-888-291-3762</td>
<td>Call this number to find HIP dental providers, or if you have questions about HIP dental services.</td>
</tr>
</tbody>
</table>

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