Anthem Blue Cross and Blue Shield
Healthy Indiana Plan℠

a health plan sponsored by the State of Indiana

Welcome

Anthem Blue Cross and Blue Shield is one of the trusted providers for the Healthy Indiana Plan, a new health plan sponsored by the State of Indiana.

Si necesita asistencia en español, usted puede solicitarla sin costo adicional contactando a su corredor o agente de cuidados de la salud. También puede visitar www.anthem.com/espanol.
Welcome to the Healthy Indiana Plan, from Anthem Blue Cross and Blue Shield.

The Healthy Indiana Plan was designed to help you get the medical care you need to stay healthy — at little or no cost to you. The plan covers preventive care services recommended by the U.S. Preventive Services Task Force, the American Cancer Society®, the Advisory Committee on Immunization Practices and the American Academy of Pediatrics. The preventive care benefit includes screenings, immunizations and other services to detect medical conditions in advance and keep you healthier in the long run.

The Anthem Blue Cross and Blue Shield Healthy Indiana Plan DOES NOT limit preventive benefits AND will pay for 100% of preventive benefits up to the annual benefit max. At the end of the year if all age and gender appropriate preventive services have been received, any amounts remaining in your POWER account up to the entire account balance (including the State’s portion) stays in your account. This is your second year. However, if you don’t get your required monthly contributions, as well as the State’s contribution, for a combined total of $1,100.

All participants will have a Personal Wellness and Responsibility Account or “POWER Account.” Participants use this account to pay for their first $1,100 of initial medical expenses. Your account contains your required monthly contributions, as well as the State’s contribution, for a combined total of $1,100.

Immunizations:
- Influenza (flu shot)
- Pneumococcal Conjugate (PCV)
- Tetanus, Diphtheria (Td)
- Measles, Mumps, Rubella (MMR)
- Hepatitis A

Screening Tests:
- Colonoscopy (familial polyps)
- Colonoscopy (biennially)
- Lipid
- Prostate cancer (digital rectal examination)
- Prostate cancer (antigen specific antigen)
- Osteoporosis

Preventive Physical Exams:
- Physical exam (annually, 18+)
- Breast exam (female, annually, 18+)
- Mammogram (female, annually, 40+)
- Chlamydia test (as part of routine pelvic exam) (female, annually, 18-25)

*This chart was taken from the U.S. Preventive Services Task Force guide. Take this chart with you to the doctor.

If you have questions, please call toll-free 1-800-553-2019.
Some definitions—so we’re all on the same page.

**POWER Account** - Also referred to as the Health Incentive Account (HIA) The Personal Wellness and Responsibility (POWER) Account is a funded account the Member may use to offset the cost of any Covered Services as they meet the benefit plan deductible. If available, Anthem will automatically use funds from the POWER Account to offset the Member’s responsibility under the deductible (except for required copayments). The POWER Account/HIA will be funded with post-tax dollars from the State and the Member and are not considered a Health Spending Account or any other type of tax-favored health spending accounts under federal law. Based on the Member’s income level, the State will determine the Member’s required Contribution amount for the benefit period. Each year the Member is enrolled, the State will contribute the difference between the amount of the POWER Account/HIA and the Member’s required annual Contribution amount. Monthly, the Member must send Anthem 1/12th of the Member’s annual required Contribution amount. Failure of the Member to contribute the required monthly amount to the account in a timely manner will result in the Member’s termination from the Plan. At the end of the year, a portion or all of the unused funds in the POWER Account/HIA (the “roll over” amount) may be made available to offset the Member’s required annual POWER Account/HIA Contribution for the next plan year. The roll over amount available to offset Contributions in the next year will be determined by the State based on the Member completing a defined and required set of preventive services for the Member’s age and gender. In the event your income level changes during the Benefit year, you are permitted to request a re-determination of your required annual POWER Account/HIA Contribution amount.

**POWER Account Contribution** - Your Contribution for the Healthy Indiana Plan is the amount you are required to contribute to the POWER Account/HIA as described in the definition of POWER Account. That amount will be determined by the State of Indiana and 1/12th will be billed to you monthly. Failure of the Member to pay the billed Contribution will result in termination from the Healthy Indiana Plan. Following termination or disenrollment from this program, you may not re-enroll for a period of at least twelve (12) months from the date of termination or disenrollment.

**Deductible** – Traditionally, a deductible is the dollar amount of Covered Services listed in the Schedule of Benefits for which you are responsible to pay each benefit period before we start to pay for Covered Services. Once the deductible is met, traditional health care benefits begin under the plan. With the Healthy Indiana plan, the POWER Account amount is set to cover your entire deductible. A **copayment** is port of the cost for health care services received—defined as a flat dollar amount. An **out-of-pocket limit** is the total amount of money (not counting your POWER Account Contribution) you have to pay each year for your health care coverage. Your POWER Account payment for covered services count toward your out-of-pocket limit. A **discount** is the reduced out-of-pocket cost you enjoy when you obtain health care services from a network provider. A **Drug formulary** is a list of brand-name and generic medications that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. You may help control the amount you pay for prescriptions by encouraging your doctor to prescribe medications from the Anthem formulary on our website at www.anthem.com.

Information about our Network Providers.

Using our network. To be eligible to receive the maximum benefits available, you must use network providers.

**Notice of provider arrangements.** Your Participating Provider’s agreement for providing covered services may include financial incentives or risk-sharing relationships which are based on utilization and quality of services. If you have any questions regarding such incentives or risk-sharing relationships, please contact Anthem or your provider.

**Accessing Covered Services.** Some services, or supplies, such as prescription drugs, require your doctor to receive an authorization from Anthem that defines and/or limits the conditions under which the service, or supply, will be covered to help you avoid any unnecessary out-of-pocket expenses. Other services, such as organ transplants, require your physician to certify, and for us to approve the service as medically necessary and the appropriate setting. Neither process is a guarantee of coverage. A **Non-network provider.** If you receive covered services from a non-network provider, you are responsible for the difference between the actual charge billed and the maximum allowable amount plus any POWER Account, copayments and non-covered charges.

And now—some really important legal information you should take the time to read.

**Who can apply.**

A single adult earning less than $20,420, or families of four earning less than $41,300 likely meet the basic financial requirements. Additional eligibility requirements include no access to employer-sponsored insurance and no insurance coverage for the previous 6 months. Additionally, if you are a parent of a child enrolled or eligible for Hoosier Healthwise, you likely qualify.

**Our appeals rights and confidentiality policy.**

If we deny a claim or request for benefits completely or partially, we will notify you in writing. The notice will explain why we denied the claim/request and describe the appeals process. You can appeal decisions that deny or reduce benefits. We encourage you to file appeals right away when you first get an initial decision from us, but we require that you file within six months of getting one. You should send additional information that supports your appeal and state all the reasons why you feel the appeal request should be granted. We will review your appeal and let you know our decision in writing within 30 days of receiving your first appeal. If you are denied coverage based on medical necessity or experimental/investigative exclusions, you can request that a board eligible or board-certified specialist review your appeal. If we deny coverage for reasons other than medical necessity or experimental/investigative reasons, you can also appeal. Please call customer service or check your contract or certificate of coverage for more information on our internal appeal and external review processes. Unless our notice of decision includes a different address, send requests for a review of appeal to:

**Anthem Blue Cross and Blue Shield**

Appeals Coordinator

P.O. Box 33200

Louisville, KY 40232-3200

**Medicaid Hearing and Appeal Process**

If you have a problem with our appeal decision, you can ask for a Medicaid Hearing and Appeal Review. You may ask for a Medicaid Hearing and Appeal Review if we:

- Denied you a service
- Reduced a service
- Ended a service that was approved previously
- Failed to give you timely service

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:

Indiana Family Social Services Administration

Hearing and Appeals Section, MS-04

402 W. Washington St., Room W292

Indianapolis, IN 46204-2773

An Administrative Law 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 a hearing.

**How to avoid Balance Billing.** We will work with you to protect you from being balance billed for services when you do not use a network provider. Since the only benefit that is available out of network (not including emergencies) is family planning it is important for you to contact customer service if you are seeking family planning services from a non-network provider; our customer service will work with you to identify a provider who has completed an Indiana Health Care Provider (IHCP) agreement so your covered family planning services can be provided and you will not be subject to balance billing. If, however, you do not call in advance and you use a provider who is not an IHCP or who is not a network provider then we can not prevent the provider you use from billing you for the difference between the provider charge and our maximum allowable amount.