Maximize Your Health

A health and financial literacy program to help ensure you get the most out of your coverage.

mhs™

Hoosier Healthwise | Healthy Indiana Plan | Hoosier Care Connect

ACCREDITED NCQA HEALTH PLAN

Agenda

1. What is Health Literacy
2. Understanding How Health Insurance Works
3. HIP Plan Overview
4. HIP POWER Account
5. Penalties for Non-Payment
6. Preventive Care: What Is It and Why Does It Matter?
7. How & When To Access Care
8. Let’s Take A Break!
9. A Cost Savings Story
10. Pharmacy Savings
11. Redetermination
12. Tips To Remember
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What is Health Literacy?

What is Health Literacy?

HEALTH LITERACY

The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.

Sources: Quick Guide to Health Literacy Report -
http://health.gov/communication/literacy/quickguide/Quickguide.pdf

What is Health Literacy?

Health Literacy affects people's ability to:

- Navigate the healthcare system, including filling out complex forms and locating providers and services
- Share personal information, such as health history, with providers
- Engage in self-care and chronic-disease management
- Understand mathematical concepts such as probability and risk

Sources: Quick Guide to Health Literacy Report - health.gov/communication/literacy/quickguide/Quickguide.pdf

What is Health Literacy?

Why is Health Literacy important?

Only **12 percent** of adults have Proficient health literacy, according to the National Assessment of Adult Literacy. In other words, nearly 9 out of 10 adults may lack the skills needed to manage their health and prevent disease.

14 percent of adults (30 million people) have Below Basic health literacy. These adults were more likely to report their health as poor (42 percent) and are more likely to lack health insurance (28 percent) than adults with Proficient health literacy.

Sources: Quick Guide to Health Literacy Report - health.gov/communication/literacy/quickguide/Quickguide.pdf

What is Health Literacy?

Why is Health Literacy important?

- Low literacy has been linked to poor health outcomes such as **higher rates of hospitalization and less frequent use of preventive services**
- Both of these outcomes are associated with **higher healthcare costs**

Sources: Quick Guide to Health Literacy Report - health.gov/communication/literacy/quickguide/Quickguide.pdf

What is Health Literacy?

Healthcare Costs:

- Persons with limited health literacy skills make greater use of services designed to **treat complications of disease** and less use of services designed to **prevent complications**

- Studies demonstrate a higher rate of hospitalization and use of emergency services among patients with limited health literacy skills

- ***This higher use is associated with higher healthcare costs***

Understanding How Health Insurance Works

Why Do I Need Insurance?

1. **<u>It's the law!</u>**

2. **It's protection for your personal finances from unexpected losses that most people can't afford.**
   - The car accident you hope you don't get into
   - The fire you hope never destroys your home
   - The health condition you hope to never get

3. **It leads to a healthier you!**
   - Health insurance gives you access to care to prevent future health problems

Insurance Basics

- Insurance is what is called a '**pure risk**'
  - Insurance companies work to minimize the amount of risk
  - Transfer risk to insurance company
  - Share risk with others that have insurance through the same company
- You pay the company '*just in case*'
- Premiums help fund losses for the entire group

Common Health Insurance Terms

Premium: Dues or monthly payment you make for health insurance.

Benefits: Services received for paying monthly premium.

Insured: You - the person covered by the policy.

Insurer: The company you have insurance through that is assuming the risk.

Cost Sharing: The sharing of costs under your insurance plan that you pay out of your pocket. This includes copays, deductibles and coinsurance.

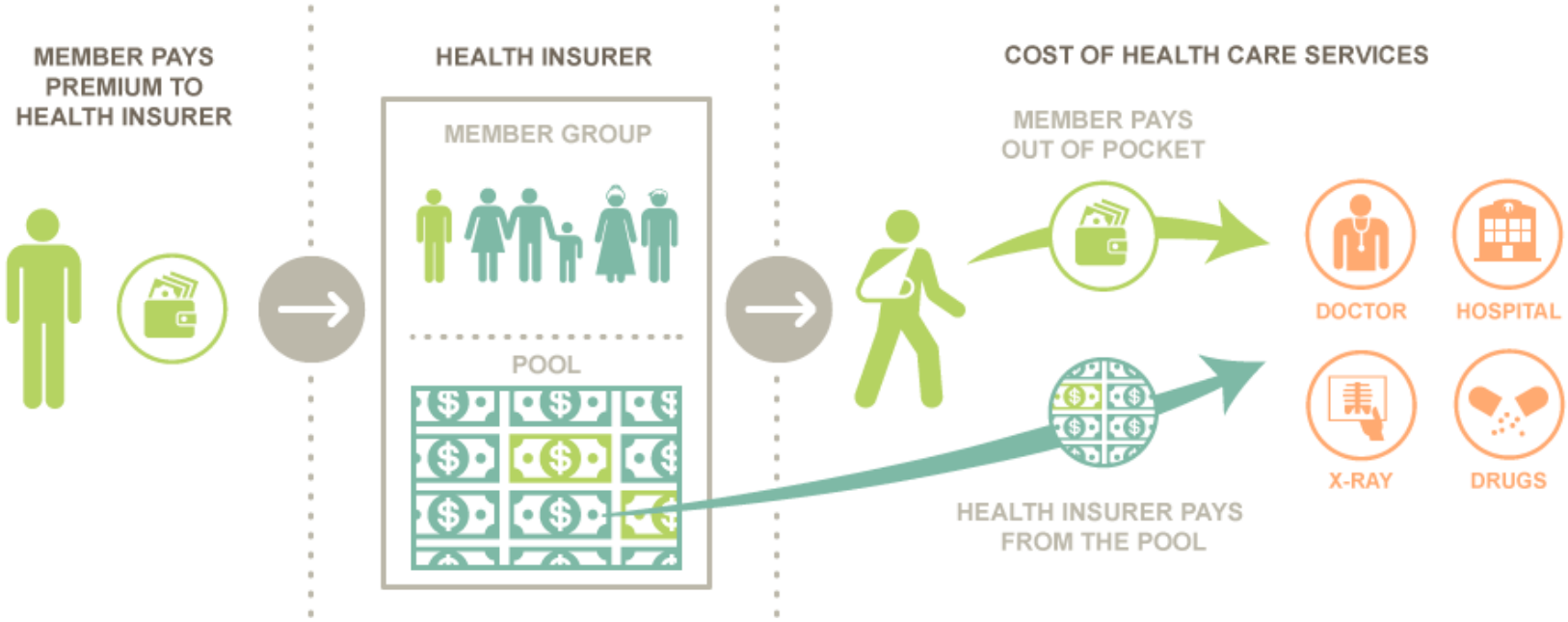
Co-pay: The amount of money you pay at time of service.

Coinsurance: The part of the medical bill you pay for services after the deductible is met.

Deductible: How much you pay, in total, for certain services before the insurance starts to pay.

Out-of-pocket Maximum: Total amount you spend for healthcare, after which the insurance company pays for your medical care for the year.

How It Works


MEMBER PAYS PREMIUM TO HEALTH INSURER
HEALTH INSURER
MEMBER GROUP
POOL
COST OF HEALTH CARE SERVICES
MEMBER PAYS OUT OF POCKET
DOCTOR
HOSPITAL
X-RAY
DRUGS
HEALTH INSURER PAYS FROM THE POOL

Example

- You get really sick and need surgery and a hospital stay. The total cost of everything is **$50,000**.

$5,000

- Without health insurance, you would be responsible for paying all $50,000! But with health insurance you are responsible for much less.

20%

- For this example, here are the terms of your health insurance:
  - deductible is $5,000
  - coinsurance is 20%
  - maximum out-of-pocket is $7,000

$7,000

Example

You are responsible for the first $5,000 in charges (deductible). After you've paid your deductible, there are $45,000 of expenses left.

You are responsible for 20% coinsurance – that is 20% of the remaining $45,000 which equals $9,000.

This is more than your maximum out-of-pocket of $7,000. So you pay $5,000 toward the deductible and only $2,000 of the coinsurance. Your insurance plan pays the rest of the covered expenses.

Your payment is $7,000. Health insurance company pays $43,000.

You have reached your maximum out-of-pocket limit for the year, so you won't have to pay anything for the rest of the year for covered medical expenses.

HIP as Your Health Insurance

- Benefits are comprehensive and similar to current Medicaid benefits
- You have cost sharing and out-of-pocket costs that vary depending on which HIP plan you have
- The first $2,500 of your annual medical expenses for covered services are your deductible and paid with your POWER Account

HIP as Your Health Insurance

HIP Plus

- You (the insured) pay a monthly premium (POWER Account Contribution) to MHS (the insurer) to receive HIP benefits
- POWER Account Contribution is based on your income
- No copays

HIP Basic

- You pay co-pays at point of service
- No monthly premium (POWER Account Contribution)

Manage Your Costs

HIP Plus is the best value!

- Rollover: All members may reduce future HIP Plus POWER Account Contributions
  - Must have remaining contribution in POWER Account, and/or
  - Receive required preventive services

- Go to annual check-ups and get all preventive services
- Ask your doctor plenty of questions
- Only go to the ER for true emergencies

Maximize Your Health

1. Choose a Primary Medical Provider (PMP)

2. Be prepared for your doctor visit
   - Bring your HIP ID card
   - Have a list of questions for your doctor
   - Talk to your doctor about your health
   - Write down doctor's instructions

3. Understand all available benefits and services

4. Stay on top of your health!

Who is MHS?

WE ARE YOUR HEALTH COVERAGE PROVIDER

- Managed Health Services (MHS) is a health coverage provider that has been proudly serving Indiana residents for more than twenty years through Hoosier Healthwise, the Healthy Indiana Plan and Hoosier Care Connect.

- MHS also offers a qualified health plan through the Health Insurance Marketplace called Ambetter from MHS, as well as a Medicare Advantage plan called Allwell from MHS. All of our plans include quality, comprehensive coverage, with a provider network you can trust.

- MHS is your choice for better healthcare.

HIP Plan Overview

Plan Overview

HIP Plus

HIP Basic

HIP State

Plan Overview: *HIP Plus*

HIP Plus

- **Preferred plan for all HIP members / Best Value**
- Must make first POWER Account Contribution (PAC) within 60 day Conditionally Eligible (CE) period
- Includes Dental, Vision & Chiropractic Coverage
- Pay monthly PAC
- No copayments for most medical services
- Depending on FPL, can lose coverage due to non-payment

Plan Overview: *HIP Plus*

Additional Benefits

- All essential health benefits
- Dental, Vision and Chiropractic
- Predictable healthcare costs
- Services for bariatric surgery and temporomandibular joint disorders (TMJ)
- Fewer limits on annual visits, speech and occupational therapists
- Comprehensive drug benefits

Monthly Payments / PAC

- Based on income & amount does not change based on health status
- Payments are due before the 1st of each month. Invoices are mailed to your home address.
- Only cost sharing is your monthly PAC

Plan Overview: *HIP Plus*

- **HIP Copayments** – *No copayments

- **Late Payments & Disenrollment**
  - Payments are due before the 1st of each month. If payment is not received, it is late/overdue.
  - Late payments will be accepted within 60 days of the date listed on their invoice. To remain in good standing, all amounts due must be paid in full, not just the amount that was due for one invoice.
  - Late payments beyond 60 days will result in disenrollment or demotion to Basic.

**The only time a member will be charged a copay is if they go to the ER for a non-emergent condition.*

Plan Overview: *HIP Plus*

- **Penalties for Non-Payment**
  - If monthly income is at or below the federal poverty level (FPL), will drop to HIP Basic
  - If monthly income is above FPL will lose coverage and need to reapply if within first 60 days OR lose coverage and be locked out for 6 months

Plan Overview: *HIP Basic*

HIP Basic

- **Fall back option / only available for income at or under 100% FPL**
- Can be more expensive
- No Dental, Vision or Chiropractic coverage
- No monthly POWER Account Contribution
- Pay copayments for most medical services

Plan Overview: *HIP Basic*

- **Fewer Benefits**
  - All essential health benefits
  - No Dental, Vision & Chiropractic
  - Limited drug benefit
- **Copayments**
  - Required payments for all medical services
  - Required payments for all pharmacy services
- ***Can be more expensive than HIP Plus!***

Outpatient Visits (including Dr. visits)	**$4**
Inpatient Services (including hospital stays)	**$75**
Preferred Drugs	**$4**
Non-Preferred Drugs	**$8**
Non-Emergency ER Visit	**$8**

Plan Overview: *HIP State Plan*

HIP State

- **For more complex issues** - Income under 138% FPL and Medically Frail, OR Low-income Parents/Caretakers, OR Low-income 19 & 20 year olds OR Transitional Medical Assistance (TMA)*
- Includes Additional Coverage – dental, vision, chiropractic, etc.
- Can be Plus or Basic
- Cannot lose coverage due to non-payment

Plan Overview: *HIP State Plan*

Eligibility

- Medically Frail
- Very Low income (<19% FPL Parents / Caretakers/19 & 20 year olds)
- Transitional Medical Assistance (TMA)

Additional Benefits

- All essential health benefits
- Dental, Vision & Chiropractic
- Transportation
- MRO
- Enhanced behavioral health services

Plus or Basic Options

- Monthly PAC, or
- Copayments for all services

HIP POWER Account

HIP POWER Account

All HIP members have a POWER Account. This is similar to a deductible. The POWER Account is a special savings account designed to pay for your healthcare.

- You and the state jointly fund your POWER account. Your portion is based on your income.

Tier	Monthly PAC Single Individual	Monthly PAC Spouses
1	$1	$1
2	$5	$2.50
3	$10	$5
4	$15	$7.50
5	$20	$10

HIP POWER Account

- The first $2,500 of your annual medical expenses for covered services are your deductible and paid with your POWER Account
- MHS uses your POWER Account to pay for each medical claim received for your healthcare
- If your annual healthcare costs are more than $2,500, the first $2,500 is covered by the POWER Account, and the remaining cost is covered by MHS at no cost to you
- If you have money left in the account at the end of your year, you can use that money to lower your PAC in the following benefit cycle

HIP POWER Account

How your POWER Account is funded if you are HIP Plus:

For example:

Your Contribution (12 monthly payments of $15)	**$180**
+ The State's Portion	**$2,320**
Total	**$2,500**

HIP POWER Account

HIP POWER ACCOUNT FUNCTIONALITY (Plus)

- When you pay your monthly PAC it is deposited into your POWER Account.
- The money in this account will pay for the first $2,500 in covered services
- You will receive monthly statements that show you how much money you have remaining in your POWER Account
- If you have money left in your account after 12 months, it can be used to LOWER your contributions in the next year

HIP POWER Account

HIP POWER ACCOUNT FUNCTIONALITY (Basic)

- HIP Basic coverage gives you a $2,500 POWER Account
- The POWER Account **CANNOT** be used to pay copays
- When you get services, you pay your copay, and your POWER Account pays the balance (up to $2,500)
- POWER Up at Redetermination!
- Preventive Services Discounts can lower your HIP Plus POWER Account Contribution if you POWER Up to Plus the next year

HIP POWER Account

MONTHLY POWER ACCOUNT STATEMENT

MHS will send you a monthly statement (included with your invoice) that shows you the amount you have paid so far in contributions as well as the money you have spent so far on medical services.

You also have access to your statement through your secure member portal account.

HIP POWER Account Statement

mhs

550 N. Meridian Street, Suite 101
Indianapolis, IN 46204

Electronic Serivce Requested

[Jane Doe]
[1234 Test Data Lane]
[Testdataville, IN 49211]

Please contact MHS Member Services if you have any questions regarding this Statement at 1-877-647-4848.

To view your POWER Account Statement online visit the MHS Secure Member Portal at mhsindiana.com or call MHS Member services at 1-877-647-4848.

Date:	[XXXXXXXXXXX]
Member ID	[XXXXXXXXXXX]
Account Holder:	[XXXXXXXXXXX]
Member Name:	[XXXXXXXXXXX]
Account Holder:	[XXXXXXXXXXX]

THIS IS NOT A BILL

The following statement is an overview of your HIP POWER Account usage for the specified benefit period. As a HIP member, the first $2,500 of your medical expenses for covered benefits are paid with a special savings account called a Personal Wellness and Responsibility (POWER) Account. Your POWER Account is similar to a deductible or health savings account. The state will pay most of this amount, but you will also be responsible for paying a portion based on your income.

HIP Plus members receive additional benefits including dental, vision and chiropractic coverage. Through the monthly POWER Account contributions, Plus members can spread the total amount of their required contribution over a 12 month period to be more affordable.

HIP Basic members do not have a contribution towards their POWER Account. Basic members also do not have dental, vision or chiropractic coverage and are responsible for copayments for all medical services and prescription medicines received.

Important Notes:

- Managing your POWER 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.
- 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.

Learn more about your POWER Account online at mhsindiana.com.

mhs

550 N. Meridian Street, Suite 101
Indianapolis, IN 46204

POWER Account activities for benefit period [1/1/2018 – 12/31/2018]
POWER Account State payment history and deductible balance as of [2/12/2018]

POWER Account activity

Date	Service	Claim Number	Provider	Amount
			POWER Account Beginning Balance:	
			POWER Account Claims Paid To Date:	
			POWER Account Remaining Balance:	

Explanation of Benefits (EOB) is available for Medicaid or Behavioral Health claims that have processed to a final status of Paid or Denied. POWER Account activity is based on claims received from your provider and updates to the POWER Account Statement are made ongoing. Dollar amounts and activity are subject to change based on claims processing. This statement shows claims activity applied to the POWER Account as of the statement date.

THIS IS NOT A BILL

Month	POWER Account Contribution	Expected From	Amount
MM/DD/YYYY	Member Required Monthly Contribution	Jane Doe	[$XXXX]
MM/DD/YYYY	Member Required Monthly Contribution	Jane Doe	[$XXXX]
MM/DD/YYYY	Member Required Monthly Contribution	Jane Doe	[$XXXX]
MM/DD/YYYY	Member Required Monthly Contribution	Jane Doe	[$XXXX]
MM/DD/YYYY	Member Required Monthly Contribution	Jane Doe	[$XXXX]
MM/DD/YYYY	Member Required Monthly Contribution	Jane Doe	[$XXXX]
MM/DD/YYYY	Member Required Monthly Contribution	Jane Doe	[$XXXX]
MM/DD/YYYY	Member Required Monthly Contribution	Jane Doe	[$XXXX]
		Member Required Monthly Contributions Total:	[$XXXX]

State Contribution	**[$XXXX]**
Member Projected Annual Contribution	**[$XXXX]**

Penalties for Non-Payment

Non-Payment Penalties

Members remain enrolled in HIP Plus as long as they make their PAC payments and are otherwise eligible.

Penalties for members not making their contribution:

At or Less than 100% FPL	Greater than 100% FPL
Moved From HIP Plus to Hip Basic	**Conditionally Eligible: Dis-enrolled from HIP*** *would need to re-apply for benefits.*
Copays for all Services	**Full Eligible: Locked out for 6 months****

Exceptions to Non-Payment Penalties

Exceptions to penalties for select HIP Plus members with household income over 100% FPL who stop paying their PAC:

- **Native Americans**
  - No required contributions
  - No copayments for using the emergency room for routine care
  - May opt out of managed care and into fee-for-service at any time, effective 4/1/15

- **Pregnant Women**
  - No required cost sharing
  - Must alert MHS or the DFR when they become pregnant at 1-800-403-0864
  - Must alert MHS or the DFR when their pregnancy ends at 1-800-403-0864

Exceptions to Non-Payment Penalties

Exceptions to penalties for select HIP Plus members with household income over 100% FPL who stop paying their PAC:

- **Medically frail**
  - Must pay copayments until outstanding PAC is paid
- **Individuals qualified for Transitional Medical Assistance** (TMA)
  - Move to HIP State Plan Basic
  - HIP State Plan Basic copayments apply

Preventive Care:
What Is It and Why Does It Matter?

Preventive Services

- Even if you feel fine, you should still see your health care provider for regular checkups. This is called preventive care. These visits can help you avoid problems in the future.

- Another part of preventive health is learning to recognize changes in your body that may not be normal.

- Being proactive in your preventive healthcare can keep you healthy AND save you money!

Preventive Services

There are specific ‘preventive services’ screenings recommended in the HIP program. All HIP members are encouraged to receive the following screenings each year:

Service	Applicable Population
Annual Physical	**All**
Blood Glucose Screen	**All, disease-specific**
Tetanus-Diphtheria Screen	**All**
Cholesterol Testing	**Males over 35 Females over 45**
Mammogram	**Females over age 50**
Pap Smear	**Females between 21-50**

Preventive Services

- MHS wants you to get your needed preventive care to keep you healthy
- MHS will give you CentAccount Healthy Rewards for getting your preventive services
- Preventive services are not paid from your POWER Account. (Those services will not be deducted from your $2,500 starting balance.)
- If you get preventive care and manage your POWER Account well, you could qualify for discounts!

Preventive Services

HOW THE ROLLOVER FORMULA WORKS

Total Power Account Contribution	**$2,500**
Member's Annual Contribution (12 monthly payments of $8)	**- $96**
State's Portion	**$2,404**

Total Power Account Contribution	**$2,500**
Member's PA Spend (funds to pay for services during benefit period)	**- $2100**
Remaining Portion	**$400**

Preventive Services

HOW THE ROLLOVER FORMULA WORKS

State's Formula for Rollover

$400 x .0384 = $15.36

Your Portion (12 monthly payments of $8, annually)	**$96**
State's Rollover	**- $15.36**
New Annual Contribution (12 monthly payments of $6.72, annually)	**$80.64**

**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.*

Preventive Services

HOW THE ROLLOVER FORMULA WORKS W/ PREVENTIVE SERVICES

Total Power Account Contribution	**$2,500**
Member's Annual Contribution (12 monthly payments of $8)	**- $96**
State's Portion	**$2,404**

Total Power Account Contribution	**$2,500**
Member's PA Spend (funds to pay for services during benefit period)	**- $2100**
Remaining Portion	**$400**

Preventive Services

HOW THE ROLLOVER FORMULA WORKS W/ PREVENTIVE SERVICES

State's Formula for Rollover *with Preventive Services*

$400 x .0384 = $15.36
$15.36 x 2 = $30.72

Your Portion (12 monthly payments of $8, annually)	**$96**
State's Rollover	**- $30.72**
New Annual Contribution (12 monthly payments of $5.44, annually)	**$65.28**

**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.*

Preventive Services

DISCOUNTS & ROLLOVER: HIP PLUS

- If you have money left over in your POWER Account at the end of your 12 month enrollment period, you can reduce your PAC for the following year.

- If half **(50%)** of your POWER Account you contributed is left over after 12 months, you can get a **50% reduction** in your contribution next year.

- AND, if you completed your preventive services, the reduction can **double**!

**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.*

Preventive Services

DISCOUNTS & ROLLOVER: HIP BASIC

- If you have money left over in your POWER Account at the end of your 12 month enrollment period, *and* you receive your recommended preventive services, you can enroll in HIP Plus with a reduced monthly PAC

- You can reduce the cost of future enrollment in HIP Plus by up to 50%

For example, if three quarters **(75%)** of your POWER Account remains after 12 months *and* you receive your recommended preventive services, then you can get a **50% reduction** in the cost of enrolling in HIP Plus

Preventive Services

DISCOUNTS & ROLLOVER: HIP BASIC

75% of Your Power Account	$1,875
+ Completing Your Preventive Services	
Reduction for your future HIP Plus Monthly PAC	-50%

**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.*

MHS CentAccount® Healthy Rewards

Members can earn dollar rewards by staying up to date on preventive care. These rewards can be used to buy things like healthy groceries, baby items and clothing, as well as over-the-counter drugs (allergy, cold meds, etc.).

YOU CAN USE YOUR REWARDS CARD AT THE FOLLOWING STORES:

DOLLAR GENERAL · FAMILY DOLLAR · meijer · RITE AID PHARMACY · Walmart Save money. Live better.

MHS CentAccount® Healthy Rewards

Service	Reward
Health Needs Screening* (Complete within 30 days of becoming a member)	**$30**
Health Needs Screening* (Complete within 90 days of becoming a member)	**$10**
Annual Well Care Visit (with primary doctor, ages 16 mo. and up)	**$20**
Per Infant Annual Well Care Visit (with primary doctor, up to 15 mo., $60 max)	**$10**
Pregnancy Rewards	***Vary by program**

Call 1-877-647-4848 or go to www.mhsindiana.com to complete the screening. To be eligible for pregnancy rewards you must notify us you are pregnant by submitting a completed Notification of Pregnancy (NOP) form or calling us. Once you notify us of your pregnancy, rewards will be provided.*

How & When To Access Care

How & When To Access Care

MEDICAL HOME

A medical home means that you establish a relationship with a *primary medical provider* (PMP), otherwise called a doctor, who you trust and who can work together with you to keep your care and records organized and up to date

Your PMP should:

- Share clear and unbiased information with you about your health and the options available to you when it comes to medical care
- Help coordinate efforts with other providers
- Keep a thorough, easily accessible, and organized record that has all your medical information

How & When To Access Care

MEDICAL HOME

- Refer you to trusted specialists or surgeons, if necessary, and work with them to establish a plan for your health care
- Organize and assist you with any transitions or changes in your care, including the transition to adult care
- Work with you and MHS to ensure that your care is properly covered and paid for with no gaps in coverage

This is the first place you go for ALL care: preventive, sick and emergency

How & When To Access Care

MEDICAL HOME

- Your PMP understands your medical history. They will ensure you get the preventive care you need. And because they know your history, they can better treat you when you are sick.
- Answer your questions
- Help identify concerns before they occur
- Treatment plans will be more accurate because they have the full picture of your situation

You can reach your PMP even when it's after hours. Be sure you have their phone numbers available at all times, so you know how to reach them when you need them.

How & When To Access Care

MEDICAL HOME

Be prepared for your doctor visit!

- ❑ Bring your MHS POWER Account ID Card
- ❑ Make a list of questions
- ❑ Bring any medical and shot records
- ❑ Arrive on time
- ❑ Describe symptoms and complaints
- ❑ Ask questions
- ❑ Take notes during each visit
- ❑ Discuss next steps
- ❑ Schedule your yearly check-ups (preventive care)

How & When To Access Care

MEDICAL HOME

What should you do?

- Make sure to choose your MHS doctor right away, and let us know
- Schedule regular check ups (preventive care)
- When you need a vaccine (like a flu shot), go to your doctor's office first, not a drugstore or health fair
- If you do get a vaccine somewhere else, be sure to let your doctor know

How & When To Access Care

MEDICAL HOME

What should you do?

- If you are sick or hurt, always call your doctor and schedule an appointment first

- Only use ER or other urgent care centers when there's a real emergency, or if your doctor's office is closed, or if the MHS 24 hour Nurse Advice Line or doctor tells you to go to urgent care

- **Most of all, find a doctor you like, and stick with him or her! *You will save money and time by having a successful medical home. And you will have better health outcomes!***

How & When To Access Care

OUT OF NETWORK DOCTOR

“Out-of-network” means the doctor or facility you want to go to is not part of the MHS provider network or Indiana Medicaid network

You could be liable for charges from unauthorized out-of-plan care if the provider is not an Indiana Medicaid Provider or if the service is not covered by your MHS plan

How & When To Access Care

OUT OF NETWORK DOCTOR

MHS only covers out-of-plan care if…

- MHS does not have a doctor in-plan to provide the services you need, or does not have a doctor in-plan within 60 miles of your home
- It is for continuity of care for a pregnant member who transferred to MHS during her third trimester
- It is for self-referral services and/or emergency medical services
- MHS authorized the out-of-plan service

How & When To Access Care

MHS 24-HR NURSE ADVICE LINE

The MHS Nurse Advice Line is a **free**, medical advice phone line staffed by bilingual licensed nurses. It is open 24 hours a day, every day of the year. Call 1-877-647-4848. **Calling the MHS Nurse Advice Line can help you avoid co-pays at the ER!**

Here are some questions you might ask:

- Questions about pregnancy
- What to do if your baby is sick
- How to deal with asthma
- How much medicine to use/give
- When to go to the emergency room

How & When To Access Care

NON-EMERGENCY / AFTER HOURS CARE

- If you are having a medical problem that is not life-threatening but you're not sure what to do, you should always call your doctor first
- Even if the office is closed, listen to the message and follow the instructions for after-hours care. MHS requires all doctors to have an after-hours phone line.
- If you cannot reach your doctor, you can call the free 24/7 MHS Nurse Advice Line
- If you are having a medical problem that is not life-threatening and need to see a doctor right away, please consider using a walk-in clinic or urgent care clinic before going to the emergency room

How & When To Access Care

URGENT CARE CENTER

Urgent Care Centers help you with illnesses or injuries that aren't life threatening but can't wait until the next day. They are staffed with nurses and doctors and can prescribe medication and complete tests to help you on your path to recovery.

- Urgent Care Centers also typically offer longer office hours and may be open on weekends

How & When To Access Care

URGENT CARE CENTER

Flu symptoms an Urgent Care Center can help with include:

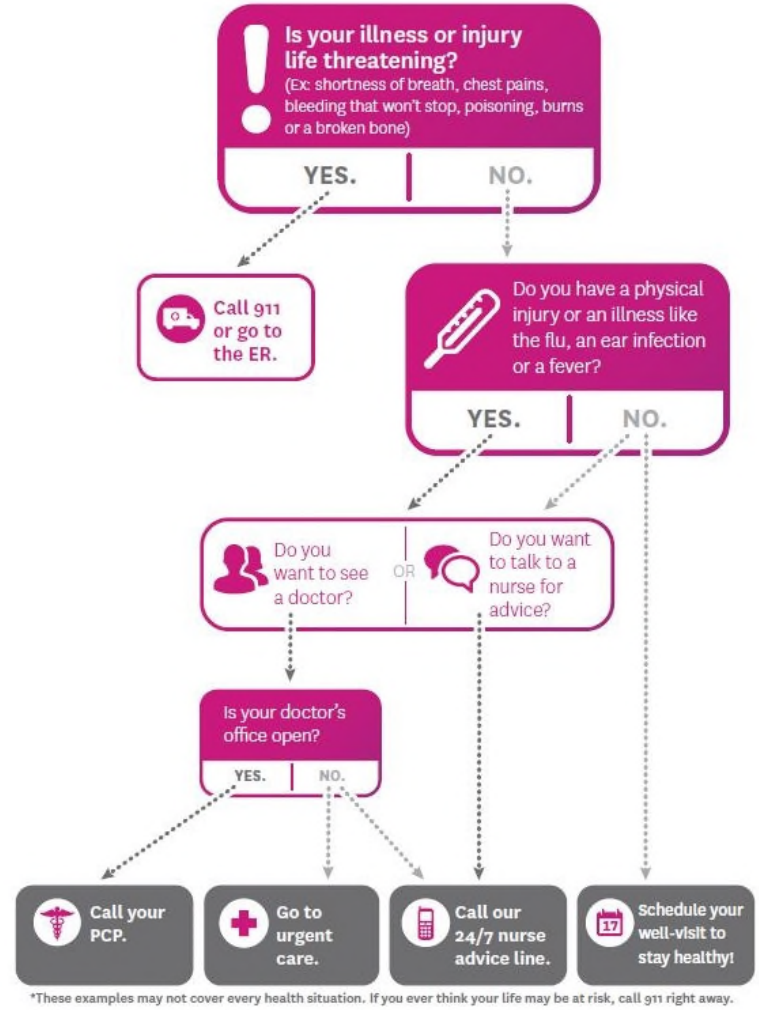
- Normal flu symptoms (if your doctor's office is closed or the doctor cannot see you for a few days)
- Severe or persistent vomiting
- Possible dehydration
- Improvement of symptoms followed by a high fever (a possible indication of new infection)

Find an MHS Urgent Care Center:
mhsindiana.com/find-a-doctor/find-a-provider-home

How & When To Access Care

Where Should You Go?

Use these questions and answers to help determine where to get care!



How & When To Access Care

EMERGENCY ROOM (ER)

When to go:

- Broken bones
- Gun or knife wounds
- Bleeding that won't stop
- If you are pregnant, and either in labor or bleeding
- Severe chest pain or heart attack
- Drug overdose
- Poisonings
- Shock (you may sweat, feel thirsty or dizzy, or have pale skin)
- Convulsions or seizures
- Trouble breathing
- Suddenly unable to see, move or speak

**This is not a complete list of when you should get emergency care. If you have a health condition that occurs often (a chronic condition), talk to your doctor about what a life-threatening medical emergency would be for you.*

How & When To Access Care

EMERGENCY ROOM (ER)

When to <u>NOT</u> go:

- Flu or colds
- Sore throats
- Earaches
- A sprain or strain
- A cut or scrape not requiring stitches
- To get medicine, or have a prescription refilled
- Diaper or other skin rash

How & When To Access Care

EMERGENCY ROOM (ER)

Emergency Care Coverage

ER visits do not need approval from your doctor or by MHS. However, if you go to the ER for a non-emergency health condition, you may have a copay of $8.

If you are unsure if you should go to the ER, call your doctor first. If you can't get ahold of your doctor, call the MHS 24 HR Nurse Advice Line. You will not have to pay an ER copay if they advise you to go to the ER.

Service	Cost
Non-Emergent ED Visit (Within benefit period)	**$8**

How & When To Access Care

EMERGENCY ROOM (ER)

Emergency Care Follow Up

- If you visit the emergency room, please give them the correct contact information for your MHS doctor. The emergency room staff will send a report to your MHS doctor that details your care plan and diagnosis.
- If you have to stay at the hospital, make sure you talk to the doctor on staff about why you are there. When you leave the hospital, the doctor on staff will give you instructions to follow.
- It is very important to follow all instructions, even if you are feeling better. The day after you go to the emergency room, or the day after you leave the hospital from an emergency admission, call to schedule a follow-up visit with your MHS doctor.

How & When To Access Care

BE PREPARED FOR HEALTH SITUATIONS

- Make sure you know the location and number of the closest urgent care clinic and emergency room to you
- You can find ones near you by using our “Find a Provider” search on our website
- You can call MHS Member Services at 1-877-647-4848 and ask for a list to be mailed to you
- If you have a life-threatening emergency, you can call 911 or your local emergency number to obtain emergency services

How & When To Access Care

MHS CARE MANAGEMENT

We have a dedicated team of nurses, social workers, behavioral specialists and program coordinators who help members with care coordination.

How & When To Access Care

MHS CARE MANAGEMENT

We offer several programs designed to help improve the health of our members through education and personal assistance:

- Pregnancy
- Diabetes
- Asthma
- COPD
- Coronary Artery Disease
- Chronic Kidney Disease
- Congestive Heart Failure
- Lead
- Behavioral Health
- Depression
- Hypertension
- ADHD
- Autism & Autism Spectrum Disorders
- Children with Special Needs
- And More!

Let’s Take A Break

A Cost Savings Story…

A savings story

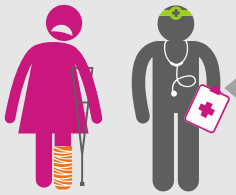
POWER Up to **HIP Plus** and pay less for complete coverage.

Meet Maria.
She's currently enrolled in **HIP Basic.**

HIP✓ HEALTHY INDIANA PLAN℠ Basic

She receives the essential benefits, but does not have dental or vision coveage. And she doesn't have the security of a predictable monthly POWER Account contribution.

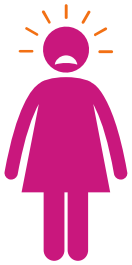
THIS CAN BE **RISKY.** If she gets sick, she may wind up paying a lot out-of-pocket.



☑ DOCTOR VISITS	$$$
☑ SURGERY	$$$
☑ PHYSICAL THERAPY	$$$
☑ PRESCRIPTIONS	$$$

Maria broke her leg. **She needs surgery.**

Maria will have copays for each of these services. These costs will add up **quickly.**



Maria spent **a lot of money** with her HIP Basic coverage.

This year,
Maria wants to **POWER Up** to **HIP Plus.**

HIP+ HEALTHY INDIANA PLAN℠ Plus

In **HIP Plus** she'll get dental and vision coverage and won't have to pay copayments for services.

This means she won't have to worry about a large, unexpected expense.

Because Maria wants to **save her money,** she chooses to **POWER Up to HIP Plus** at redetermination.

And she can **save money** every year by being proactive with preventive healthcare. **She can reduce or eliminate her monthly POWER Account contribution** next year if she manages her POWER Account wisely.

POWER Up

at redetermination and get the coverage you deserve!

Visit **mhsindiana.com** or call

1-877-GET-HIP-9

Pharmacy Savings

Pharmacy Savings

Benefits of HIP Plus in Your Pharmacy Needs

Because you chose to POWER Up to Plus, you receive better pharmacy benefits including:

- No copays
- Eligible for MTM (medication therapy management)
- Option for preferred mail order
- Option for specialty pharmacy

Pharmacy Savings

Benefits of HIP Basic in Your Pharmacy Needs

Drug benefits are limited in HIP Basic:

- Copays for all prescriptions
- Limited Preferred Drug List (PDL)
- Option for specialty pharmacy

Pharmacy Savings

When you need either prescription or over-the-counter (OTC) drugs, your doctor will write you a prescription. Your doctor will either contact your pharmacy directly, or you can take the written prescription to your pharmacy.

Find a Pharmacy

All MHS members must use a pharmacy in the Indiana Medicaid network, including mail-order pharmacies. You can search for a pharmacy online at mhsindiana.com/find-a-doctor/find-a-provider-home

All MHS members also have access to specialty pharmacy services when needed.

Pharmacy Savings *(cont.)*

COVERED PRESCRIPTIONS

- Prescription drugs are covered if the drug is approved by the U.S. Food and Drug Administration (FDA). This includes self-injectable drugs (such as insulin), and drugs to help you quit smoking. OTC drugs are only covered if listed in the OTC drug formulary.

- Items that you need to care for diabetes are also a covered benefit. This includes items such as needles, syringes, blood glucose monitors, test strips, lancets and glucose urine testing strips. You can get these items at your pharmacy.

Pharmacy Savings

PREFERRED DRUG LIST (PDL)

Your pharmacy benefit has a Preferred Drug List (PDL). The PDL shows the drugs covered under the pharmacy benefit. A team of doctors and pharmacists updates this list four times a year.

- Updating this list ensures the drugs are safe and useful for you and cost-effective for the Indiana Medicaid program. Some OTC drugs are covered by Indiana Medicaid.
- Even listed OTC drugs require a doctor's prescription to be covered
- You can find the PDL for your benefit package at mhsindiana.com

Pharmacy Savings

NON-COVERED PRESCRIPTIONS

- Drugs that do not have FDA approval
- Experimental or investigational drugs
- Drugs to help you get pregnant
- Drugs used for weight loss
- Cosmetic or hair-growth drugs
- Drugs used to treat erectile problems
- Drugs not on the OTC Drug Formulary

Pharmacy Savings

GENERIC AND PREFERRED DRUGS

Your pharmacist will give you generic drugs when your doctor has OK'd them.

- Generic drugs **are the same** as brand-name drugs and make healthcare more affordable

- Generic drugs **must be used** when available. If they are not available, brand-name drugs may be used. Or, if the brand-name drug is less costly, then it may be considered the "preferred drug".

Pharmacy Savings

PRIOR AUTHORIZATION FOR DRUGS

Some drugs may need prior authorization before they are covered. To get authorization, your doctor will need to provide information about your health to MHS, and then a decision will be made if MHS can pay for the drug.

- Your doctor must send a request for prior authorization if:
- A drug is listed as non-preferred on the PDL or if certain conditions need to be met prior to you receiving the drug
- You are getting more of the drug than is usually prescribed
- There are other drugs that should be tried first

Pharmacy Savings

PRIOR AUTHORIZATION FOR DRUGS

- MHS covers some drugs injected in a doctor's office or clinic and some medications taken by mouth that are classified as "specialty drugs". These drugs must have prior authorization. The list of specialty drugs is available on our website.

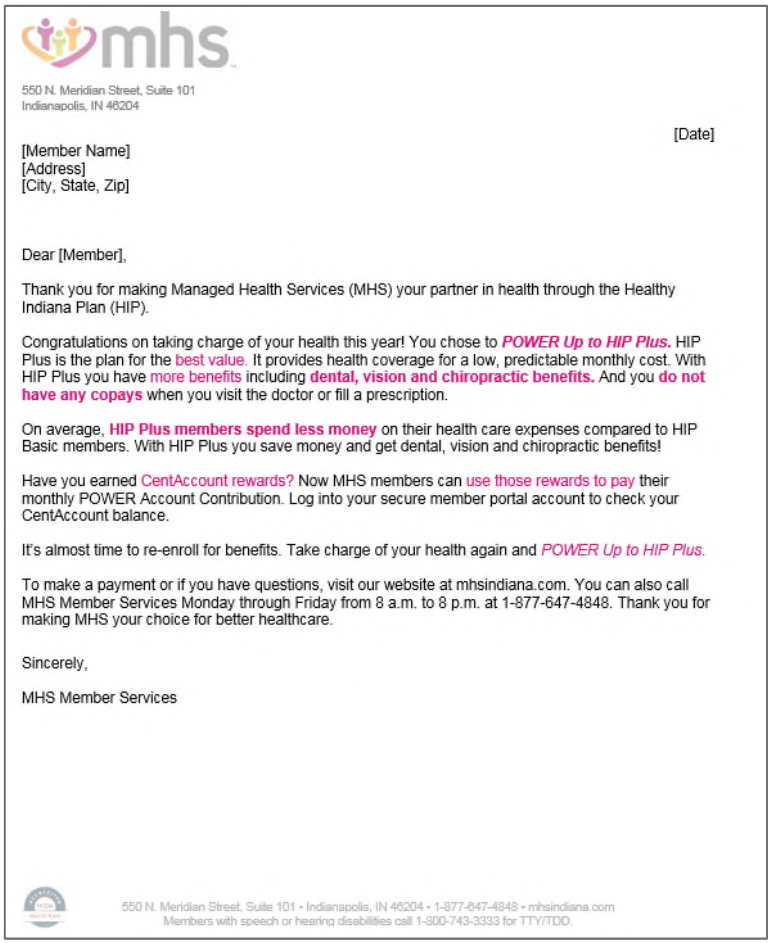
- In most cases, you may get up to a three-day (72 hour) supply of a drug that requires prior authorization while you are waiting for a decision. The decision will be made within one day (24 hours), not including Sundays or some holidays. Your doctor will be notified of the decision. Your doctor can find prior authorization forms at mhsindiana.com.

Redetermination

Redetermination

At the end of your benefit year, you will need to either **re-apply** or **confirm** information with the state to show that you are still eligible for HIP. Contact your state worker through the Department of Family Resources to find out what is required for you to continue your benefits.

It can take about 45 days to re-apply or confirm your information with the state. To help you, MHS will call you, send a letter and send you an email (if you are signed up for email updates) to remind you when you are 45 days from your last day of eligibility.



550 N. Meridian Street, Suite 101
Indianapolis, IN 46204

[Date]

[Member Name]
[Address]
[City, State, Zip]

Dear [Member],

Thank you for making Managed Health Services (MHS) your partner in health through the Healthy Indiana Plan (HIP).

Congratulations on taking charge of your health this year! You chose to ***POWER Up to HIP Plus.*** HIP Plus is the plan for the best value. It provides health coverage for a low, predictable monthly cost. With HIP Plus you have more benefits including **dental, vision and chiropractic benefits.** And you **do not have any copays** when you visit the doctor or fill a prescription.

On average, **HIP Plus members spend less money** on their health care expenses compared to HIP Basic members. With HIP Plus you save money and get dental, vision and chiropractic benefits!

Have you earned CentAccount rewards? Now MHS members can use those rewards to pay their monthly POWER Account Contribution. Log into your secure member portal account to check your CentAccount balance.

It's almost time to re-enroll for benefits. Take charge of your health again and *POWER Up to HIP Plus.*

To make a payment or if you have questions, visit our website at mhsindiana.com. You can also call MHS Member Services Monday through Friday from 8 a.m. to 8 p.m. at 1-877-647-4848. Thank you for making MHS your choice for better healthcare.

Sincerely,

MHS Member Services

550 N. Meridian Street, Suite 101 • Indianapolis, IN 46204 • 1-877-647-4848 • mhsindiana.com
Members with speech or hearing disabilities call 1-800-743-3333 for TTY/TDD.

Redetermination

Redetermination Plus

When you enroll in HIP you are eligible for 12 months. Forty-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 Plus, you will receive a request for additional information. You must complete and return the requested information to remain eligible.

Redetermination Basic

When you enroll in HIP you are eligible for 12 months. Forty-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. After 12 months of enrollment you will have the opportunity to change from HIP Basic to HIP Plus by paying a required contribution to your POWER account.

Redetermination

POWER UP to Plus!

This is your time to either maintain your HIP Plus benefits OR POWER Up to HIP Plus from HIP Basic.

Remember, HIP Basic can be much more expensive than HIP Plus, and the benefits are not as good!

Take charge of your health at redetermination and POWER Up to **HIP Plus**. Make sure you pay your POWER Account contribution.

Tips to Remember

Tips to Remember

MAKE PAYMENTS ON TIME

- POWER Account contributions (PAC) are due before the 1st of each month
- Always have the ID number listed on your POWER Account Invoice ready
- Avoid non-payment lockout

Tips to Remember *(cont.)*

MHS GIVES YOU LOTS OF EASY WAYS TO PAY!

- **Online**
  - Set up reoccurring auto pay thru the secure member portal.
  - One time payment using a credit/debit card at mhsindiana.com.
- **In person**
  - Using cash at a MoneyGram retailer like CVS/pharmacy or Walmart (Receive Code 15200). Find a MoneyGram location at 1-800-926-9400.
- **By mail with check, money order or credit/debit card to**:
  - Managed Health Services
    Member Mailstop 16253487
    PO Box 660160
    Dallas, TX 75266-0160

Tips to Remember

MHS GIVES YOU LOTS OF EASY WAYS TO PAY!

- **By phone with credit/debit card at 1-877-647-4848**
- **ETF (Electronic Funds Transfer)**
- **Payroll deductions by your employer**
- **Third party payers** - Non-member payments using the online form

Tips to Remember

ALWAYS CARRY YOUR HIP MEMBER ID CARD

- You must show your HIP member ID card each time you get medical care or go to the pharmacy
- If you do not show your ID card, you may have to pay for your care

Lose your card?
Call MHS Member Services: 1-877-647-4848.

**If you receive a bill for covered services or are told to file a claim, please contact MHS Member Services right away.*

Tips to Remember *(cont.)*

COMPLETE YOUR HEALTH NEEDS SCREENING (HNS)

MHS will reward you for completing the HNS:

- Earn $30 within the first 30 days
- Earn $10 within the first 90 days

We will call you before 90 days are up, but you don't have to wait!

Go to mhsindiana.com/hns, or call MHS Member Services and ask to take the survey.

Tips to Remember

CHOOSE YOUR DOCTOR RIGHT AWAY

1. **Find a list of doctors in your area:**
   - Go online at mhsindiana.com/find-a-provider, or
   - Call MHS Member Services

2. **Pick your doctor**

3. **Tell us! You can tell us one of three ways**:
   - Complete the doctor selection form & send to MHS
   - Through the Member Portal at mhsindiana.com/login
   - Call Member Services at 1-877-647-4848

Afterward, MHS will send you a letter confirming the doctor(s) you chose

Tips to Remember

CREATE A MEMBER PORTAL ACCOUNT

- View your summary of benefits
- Find explanation of benefits statements
- Find/change your doctor
- See doctor quality reports
- View your claims (health services you've gotten and the cost of those services)
- Review HIP POWER Account payments and other information
- Communicate with MHS Member Services

Go to mhsindiana.com and click on "Login / Create Account" under "For Members."

Tips to Remember

MONITOR YOUR POWER ACCOUNT BALANCE

- Remember, MHS will send you a monthly POWER Account statement. However, your best bet is to regularly log into your secure member portal account to view your account and the real time balance.

- Be sure to manage your account well and get preventive services discounts for rollover next year!

Words To Know…

Words to Know…

MANAGED HEALTH SERVICES (MHS)

Your health insurance provider through your enrollment in HIP.

COPAYMENT

The set amount of money you pay at the time of a certain medical service. You also might pay this when you pick up a medication. The copay amount may vary depending on the type of healthcare service.

COST SHARING

The sharing of costs under your insurance plan that you pay out of your pocket. This includes items such as copays, deductibles and coinsurance.

Words to Know…

COST SHARING

- **HIP Plus Cost Sharing** – Your monthly POWER Account Contribution. (No copays)

- **HIP Basic Cost Sharing** – Your copayments that are required for each medical service or pharmacy purchase. (No POWER Account contribution)

DEDUCTIBLE

The fixed amount of money you must pay for certain services each year before your insurance company begins to pay. After you meet your deductible, your health insurance will begin to pay for these services.

Words to Know…

DFR

The Family and Social Services Administration's Division of Family Resources. These are the county welfare offices.

EFFECTIVE DATE

The date that your insurance coverage begins.

FSSA

The Indiana Family and Social Services Administration. This is the single state department responsible for the administration of the HIP program and other public or health-related programs.

Words to Know…

ESSENTIAL HEALTH BENEFITS

The comprehensive package of items and services required to be covered through health insurance by the Affordable Care Act.

Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Words to Know…

FEDERAL POVERTY LEVEL (FPL)

This is the measure of income level issued annually by the Department of Health and Human Services. These levels are used to determine eligibility for certain programs and benefits.

HEALTH NEEDS SCREENING (HNS)

The health questionnaire members must complete within 90 days of MHS membership. Allows MHS to match a member's needs with the right programs and services.

Words to Know…

IN-NETWORK

An in-network provider is a provider that is contracted with a particular health insurance plan. Typically, if you visit an in-network provider, the cost is less than visiting an out-of-network provider.

MEMBER PORTAL

This is a free and secure online account that is specific to you. It includes information about your benefits, claims information, payment history, CentAccount balance info, and more. You can also find or change your doctor and communicate with Member Services through your portal account.

Words to Know…

PREMIUM

The amount of money you pay each month in order to have health insurance. In HIP, this is called a POWER Account Contribution.

POWER ACCOUNT CONTRIBUTION (PAC)

The monthly premium that needs to be paid to maintain HIP Plus benefits. Your POWER Account contribution amount is based on your income.

POWER ACCOUNT STATEMENT

MHS will send you a monthly statement (included with your invoice) that shows you the amount you have paid so far in contributions as well as the money you have spent so far on medical services. You can also check your balance online thru your secure member portal account.

Words to Know…

PREVENTIVE CARE

Routine healthcare that includes screenings, checkups and patient counseling to prevent illness, disease or other health problems.

PRIMARY MEDICAL PROVIDER (PMP)

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

PROVIDER

Any medical, dental or behavioral health professional who may provide care for our members. Most often it refers to doctors.

Words to Know…

PREFERRED DRUG LIST (PDL)

Preferred Drug List. Your pharmacy benefit has a Preferred Drug List (PDL). The PDL shows some of the drugs covered under the pharmacy benefit.

OTHER PAYER

Employers, non-profits and other non-members can make some or all of your POWER Account contribution. Anyone paying on your behalf needs to complete the 'Employer, Non-Profit or Non-Member Payer' form included with your invoice.

OUT-OF-NETWORK PROVIDER

A provider who doesn't have a contract with MHS to provide services to you. You may pay more to see an out-of-network provider.

Words to Know…

OUT-OF-POCKET COSTS

Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles and copays for covered services, plus all costs for services that aren't covered.

SELF-REFERRAL

A covered service you can get without having the approval of your MHS doctor, MHS or anyone else. You can self-refer for special services that do not require pre-service review by MHS or by your PMP.

Questions?

Contact Us

- Online: mhsindiana.com/contact-us

- By phone: 1-877-647-4848
  Monday thru Friday, 8 a.m. – 8 p.m.