WE GET YOU *COVERED.*

mhs™

Member Handbook

Important information for you and your family.

HiP HEALTHY INDIANA PLAN

mhsindiana.com • 1-877-647-4848 • TTY/TDD: 1-800-743-3333

0126.MA.M.JB.1

The information in this book is available in other languages or formats, including Spanish, large print, Braille or audio CD. Please contact MHS Member Services by phone at 1-877-647-4848 or online at mhsindiana.com if you need this information in another language or format.

WELCOME TO MHS!

Thank you for making MHS your choice for better healthcare through your enrollment with the Healthy Indiana Plan (HIP). Here are the next steps you should take as a new member.

Complete Your Health Needs Screening Complete the survey online, over the phone at 1-888-252-3410 or at a Walmart pharmacy kiosk. ***Complete it within 30 days of becoming a member to get a $30 My Health Pays® reward.***

Sign Up for your Secure Member Portal Account Your portal account gives you access to your secure information, such as claims, your doctor's office's information, My Health Pays® balances and more.

Choose Your Doctor Use the Find a Provider search to choose your doctor at mhsindiana.com. Then, sign in to your portal account or call us at 1-877-647-4848. ***You can earn a $15 My Health Pays® reward for using your portal account to choose a doctor within the first 30 days of becoming a member.***

Visit Your Doctor After you choose your doctor, set up an appointment for a checkup right away. This is your new medical home.

Read Your Handbook and Quick Reference Guide Your Handbook and Quick Reference Guide tell you about your benefits and the services and programs you can use as a member.

If You are Pregnant, You Can Earn a My Health Pays® Reward by Submitting a Notification of Pregnancy form to MHS within your first trimester ($50) or within your second trimester ($25). ***Submit using the Member Portal or by calling 1-877-647-4848.***

MHS Benefits U! Text MHSTEXT to 36698 to get messages and reminders throughout your membership with MHS. (Standard messaging rates apply. Text STOPMHS to quit at any time.)

TABLE OF CONTENTS

HIP Plans Color Coding in this Handbook

Depending on your income status, pregnancy status, and if you pay a monthly contribution, you may be in one of several HIP plans. To help show you the differences throughout your handbook, we have color-coded these plans:

Orange: HIP Plus

Blue: HIP Basic

Green: HIP State Plan (Plus and Basic)

Pink: HIP Maternity

Your benefits may vary, depending on what plan you are in. If you're not sure which plan you're in, you can login to mhsindiana.com to find out. Or, you can call MHS Member Services at 1-877-647-4848.

This member handbook gives an overview of your healthcare benefits. MHS wants to make it easy for you to make the most of your benefits and services. MHS can help you 24 hours a day, seven days a week.

How to Contact Us

Member Services:	1-877-647-4848, Monday – Friday, 8 a.m. – 8 p.m. MHS is closed on the following days: New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Day
TTY/TDD Line:	1-800-743-3333, (for members with speech or hearing disabilities)
24 Hour Nurse Advice Line:	1-877-647-4848
Emergency:	911
Website:	mhsindiana.com
By Mail:	MHS Member Services 429 N Pennsylvania St., Suite 109, Indianapolis, IN 46204

Stay Connected with MHS Online

Blog: mhsindiana.com

Managed Health Services-MHS

Managed Health Services

Emails from MHS

MHS will send you emails from communications@mhsindiana.com about your specific benefits, events in your city or town, and tips for healthy lifestyles. Make sure your email address is up to date with the State to get this important information.

MHS Member Services is here to help!

We can answer your questions about your health insurance. Here are some reasons you could contact Member Services:

- If you need to choose or change your doctor
- Complete your Health Needs Screening
- If you get an invoice or bill from your doctor or healthcare provider
- Get language assistance

MHS offers a 24-hour phone service in English, Spanish and Burmese. You can leave a message, and MHS will call you back within one business day. Please contact MHS Member Services if you need help understanding any MHS written materials, such as brochures, flyers, letters and this handbook. We can send you materials in a different language, such as Spanish or Burmese. We can also send you materials in a different format such as large print, Braille or audio CD. You may also contact MHS Member Services to suggest changes to any of the policies, services and processes MHS provides to you as a member.

Keep in Touch

Always let MHS and the State know if you move or get a new phone number or email address. If you move to another county or if you move more than 30 miles from your doctor's office, you may not be able to keep your doctor. Please call and talk to MHS Member Services if you move.

The Indiana DFR needs to know of changes to your current information. Call 1-800-403-0864 or go to FSSABenefits.IN.gov, create an account or click "Report a Change."

When you report the change, you may be able to request a recalculation of your POWER Account contribution amount. Learn more about this on page 21.

MHS 24 Hour Free Nurse Advice Line

Everyone has questions about their health. If you have a question, you can reach the MHS 24 hour nurse advice line at 1-877-647-4848. 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. 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

Language Assistance

MHS provides bilingual staff or an interpreter to help members who speak languages other than English. We can help schedule appointments and answer questions over the phone. This service is free to use. Call MHS Member Services at 1-877-647-4848 and ask for language assistance.

Hearing impaired members can call the Indiana Relay Service at 1-800-743-3333 for TDD/TTY service. This number can be used anywhere in Indiana. Ask the operator to connect you to MHS at 1-877-647-4848, or to any other number. Tell your doctor if you need a sign language interpreter for your medical visits.

MHS Website: mhsindiana.com

MHS' website helps you get answers when it's convenient for you. If you don't have a printer, you can ask MHS to mail you any forms, web pages or any other printable information on mhsindiana.com or the MHS Facebook page. These are some important pages on our website:

- **mhsindiana.com/HIPscreening**
  When you take your health needs screening within 30 days of joining MHS, you get a $30 My Health Pays® reward. Or take it within 90 days of joining MHS, and get a $10 My Health Pays® reward! Learn more about My Health Pays® on page 40.

- **For Members > Healthy Indiana Plan > Benefits & Services**
  Find member updates and member guides, such as a copy of this handbook, brochures and how-to guides. You can also find copies of member forms, member newsletters and information about special MHS programs and services.

- **mhsindiana.com/find-a-provider**
  Find MHS in-plan doctors, specialists, hospitals and other facilities using this quick and easy online search.

- **For Members > Healthy Indiana Plan > Health & Wellness**
  Our free health library will help you find answers to your health questions. There are more than 4,000 health information sheets on a variety of health topics to help you care for yourself and your family.

- **mhsindiana.com/contact-us**
  Send MHS Member Services a message.

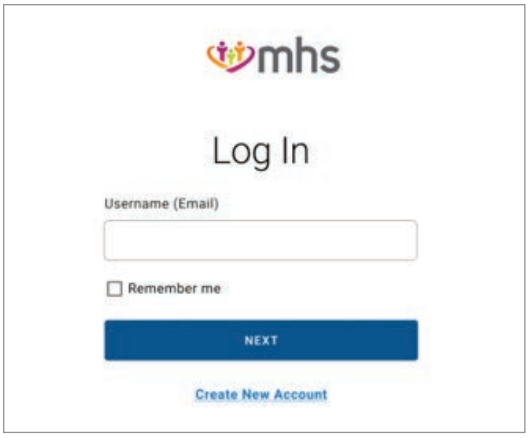
Sign Up for an MHS Secure Member Portal Account

Create an account and access tools that help you manage your healthcare faster and easier - all without having to pick up a phone:

- View your summary of benefits, including pharmacy benefits
- Find Explanation of Benefits (EOB) statements
- Find/change your doctor
- See doctor quality reports
- View and track your claims. You can see the amount approved, amount paid and date paid.
- Communicate with MHS Member Services
- Request, order or print an ID card
- Learn about referrals for care and if an authorization is required

Adding a Dependent to Your Secure Member Portal

1. On the Member Homepage, Click on **Account.**
2. Click on **Member on this Plan.**
3. Enter **Member ID** and **Date of Birth.**
4. Click **Add Dependent.**



YOUR COVERAGE YEAR

In Your First 30 Days

Health Needs Screening

The Health Needs Screening (HNS) is a questionnaire that asks you about your health history and if you have any healthcare conditions. We want to know about your health right away so we can help match your needs with the right healthcare team. That's why we offer a way to earn reward dollars with the My Health Pays® program. MHS will give you a $30 My Health Pays® reward if you complete the HNS within 30 days of becoming a member. Or you can get a $10 My Health Pays® reward for completing it within 90 days of becoming a member.

We will call you before 90 days are up, but you don't have to wait. Go to mhsindiana.com/HIPscreening, call MHS Care Engagement at 1-317-643-8094 and ask to take the survey, or go to a Walmart pharmacy kiosk.

Choose Your Doctor Right Away

MHS cares about you having a successful medical home. That begins with choosing MHS doctors for you and your family. As an MHS member, you get to choose the doctor you want. He or she will help manage your healthcare and help you get the services your family needs. It's important you choose the doctor you want within 30 days of becoming an MHS member. If you don't, MHS will choose a doctor for you.

How to Choose a Doctor

First, find a list of doctors in your area. MHS' local provider network is the group of doctors, hospitals and other healthcare providers who have agreed to provide you with your healthcare services.

To find a provider, you can call Member Services at 877-647-4848 and ask for a list or visit mhsindiana.com and use the Find a Provider tool. This tool will have the most up to date information about the provider network, including information such as name, address, telephone numbers, whether they are accepting new patients, languages spoken, gender, specialty and board certification status. For more information about a provider's professional qualifications, medical school and residency, call Member Services..

Next, pick your doctor from the list. You can choose from the following types of MHS doctors:

- Family Practice
- General Practice
- Internal Medicine
- OB/GYN (pregnant members only)
- Pediatrician (0-17 years old)

Last, tell us! You can tell us one of two ways:

- Choose your doctor through your Secure Member Portal Account 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.

In Your First 90 Days

Set up a First Appointment and Get to Know Your Doctor

After you choose your doctor, please call the doctor's office within 60 days to make an appointment for your first checkup or preventive care visit. Get help making an appointment by calling our MHS Care Engagement at 888-252-3410. MHS cares about you having a successful medical home. This means you need to develop a relationship with a doctor you trust and go to for all your medical care. This doctor is also called your Primary Medical Provider (PMP).

In Your First 6 Months

Get Your Preventive Care

The best way to stay healthy is to get your regular preventive care. Preventive care visits are FREE for all MHS members. Adults and children alike need preventive care and immunizations. Go to page 12 for a schedule of yearly exams, screenings and immunizations.

As a **HIP Plus** or **HIP State Plan Plus** member, getting certain preventive exams and screenings gives you HIP discounts, good towards your next benefits year. Learn more on page 14.

In Your First Year

Keep Your Benefits

As your partner in health, we want you to continue receiving benefits if you need them. You will pick your health plan once per year and stick with that health plan all year, January through December. This is your benefit year. Even if you leave the program and return during the year, you will stay with the same health plan.

Benefit Year: January – December. Your benefit limits and POWER Account reset each January.

Each fall, November 1-December 15, you will have the chance to change your health plan for the next benefit year. You can do this by calling 1-877-GETHIP-9 and letting them know you want to pick a new health plan for the next year. If you like MHS, do nothing! You will be automatically re-enrolled with us for next year.

This does not change your eligibility period for the program. You still have to go through your redetermination process every 12 months. This will occur based on what month you entered the program. You will get a reminder from FSSA that it is time for your eligibility redetermination. If you do not respond as directed, you could lose coverage.

Eligibility Period: 12 months that starts when you are approved for coverage. This can be different for each person.

Forty-five days before the end of your 12-month eligibility period, the State will begin a process to see if you are still eligible for HIP. During this 45-day period the State will request additional information from you to determine your continued eligibility. **You must complete and return the requested information to remain eligible.**

If you are currently in the **HIP Basic** program, you will have the opportunity to move from **HIP Basic** to **HIP Plus** by paying a required contribution to your POWER Account. Remember, **HIP Plus** members don't pay copays, and have greater benefits, including dental, vision and chiropractic coverage. Find out more about **HIP Plus** on page 15.

Do you know the date of your redetermination? Go to FSSABenefits.IN.gov or call 1-800-403-0864 for help.

Covered Services

A covered service is a service that is paid for under your health benefits through Healthy Indiana Plan. Some services may not be covered under your benefit package. If a service is not covered, your doctor must tell you if you have to pay for the service. Some benefit packages have a monthly contribution payment and copays you must pay.

Your Benefits

The Healthy Indiana Plan (HIP) provides affordable health insurance for uninsured adult Hoosiers between the ages of 19-64. The program is sponsored by the State. It offers full health benefits including hospital services, mental health care, physician services, prescriptions and diagnostic exams.

Depending on your income status, pregnancy status, and if you pay a monthly contribution, you may be in one of several HIP plans, including **HIP Plus**, **HIP Basic**, **HIP State Plan** and **HIP Maternity**. Your benefits may vary, depending on what plan you are in. If you're not sure which plan you're in, you can find out through your secure portal account at mhsindiana.com/login. Or, you can call MHS Member Services at 1-877-647-4848.

The following benefits grid lists covered if the benefit is covered for all HIP plans. If a certain benefit is only available for some HIP plans, those plans are listed.

BENEFIT	COVERAGE
Authorized therapies – physical, speech, occupational, respiratory	Covered
Chiropractic	HIP Plus, State Plan Plus & Maternity
Continued care after hospital stays (post stabilization)	Covered
Cosmetic procedures	No
Developmental delay evaluation and treatment	No
Diabetes strips, blood sugar monitoring	Covered
Doctor visits (services from your PMP/family doctor)	Covered
During and after pregnancy care - Call MHS right away if you become pregnant	Covered
Foot care	Covered with restrictions*
Free ride services to doctor visits, pharmacy, emergency care and Medicaid redetermination appointments	State Plan & Maternity Enhanced Benefit for MHS HIP Plus and HIP Basic members
Hearing aids (1 per member every 5 years)	Covered
Home healthcare	Covered
Hospice	Covered
Hospital stays	Covered
Labs/X-rays	Covered
Medical supplies/equipment	Covered
New or experimental services or alternative therapies	No
Orthotics – leg braces, orthopedic shoes, prosthetics	Covered
Prescriptions (copay may be required)	Covered
Referrals to specialists	Covered
Routine dental care	19-20 year olds, HIP Plus, State Plan & Maternity
Routine visions (optical) care	19-20 year olds, HIP Plus, State Plan & Maternity
Surgeries (outpatient)	Covered
Tests to find if you have a health condition (diagnostics)	Covered
Treatment for learning disability, problem solving or memory issues	State Plan
Well-child checkups (Early Periodic Screening, Diagnosis & Treatments)	Covered (through the month of the member's 21st birthday)

*Covered when medically necessary for the treatment of diabetes and lower extremity circulatory diseases.

Healthy Indiana Plan Self-Referral Services
You can receive some services without seeing your doctor to get a referral, as long as you visit an Indiana Medicaid provider. You can find a list of Indiana Medicaid providers at indianamedicaid.com.

The following self-referral services do not require a referral from your PMP or approval from MHS.				
Members may self-refer to any qualified provider enrolled in Medicaid:	HIP State Plan	HIP Basic	HIP Maternity	HIP Plus
Chiropractor	Covered		Covered	Covered
Routine vision (optical) care	Covered		Covered	Covered
Psychiatric services	Covered	Covered	Covered	Covered
Podiatry (foot) care	Covered*	Covered*	Covered*	Covered*
Family planning	Covered	Covered	Covered	Covered
Emergency services	Covered	Covered	Covered	Covered
Urgent care	Covered	Covered	Covered	Covered
Immunizations	Covered	Covered	Covered	Covered
Diabetes self-management	Covered	Covered	Covered	Covered
Services are self-referral if given by an in-network provider:	HIP State Plan	HIP Basic	HIP Maternity	HIP Plus
Routine dental care	Covered		Covered	Covered
Behavioral health (mental health, substance abuse, chemical dependency)	Covered	Covered	Covered	Covered

*Covered when medically necessary for the treatment of diabetes and lower extremity circulatory diseases.

Durable Medical Equipment

Durable Medical Equipment (DME) consists of items which:
- Are primarily and customarily used to serve a medical purpose
- Are not useful to a person in the absence of illness or injury
- Are reusable
- Are appropriate for use in the home
- Are not useful to a person in the absence of illness or injury
- Are ordered or prescribed by a physician
- Can stand repeated use

DME includes, but is not limited to, wheelchairs (manual and electric), hospital beds, traction equipment, canes, crutches, walkers, kidney machines, ventilators, oxygen, monitors, pressure mattresses, lifts, nebulizers, bili blankets and bili lights.

Please speak with your Primary Medical Provider (PMP) if you have a question about DME. Your PMP can also assist you in meeting prior authorization requirements. If you need assistance locating a DME vendor please contact MHS Member Services at 1-877-647-4848.

Referrals and Prior Authorizations

What is the difference between a referral and a prior authorization?
Referral – A request (verbal, written or telephonic communication) by a Primary Medical Provider (PMP) for specialty care services
- This is a doctor-to-doctor service
- MHS does not require referrals for services

Prior Authorization – An approval from MHS for a member to receive services that are designated as needing approval prior to treatment and/or payment.
- This is a communication between your doctor and MHS

SCREENINGS	AGE IN YEARS: 18	20	25	30	35	40	45	50	55	60	65	70	75+
Well-Person Exam Talk to your doctor about physical, mental and lifestyle issues to promote a healthy life.	Every year for both men and women												
Blood Pressure Know your numbers – Keep your blood pressure under control.	Every year for both men and women												
Body Mass Index (BMI) Stay at a healthy weight. Find out your BMI.	Every year for both men and women												
Abdominal Aortic Aneurysm Screening One-time screening by ultrasound for men with a history of smoking.											Men at higher risk		
Breast Cancer Screening Universal screening at age 50; age 40 talk with your doctor.						Women at higher risk		All Women					
Cervical Cancer Prevention Age 21-65: PAP test every 3 years. Age 30-65: Every 5 years if your have both a PAP test and an HIV test.		Women											
Chlamydia Screening *Sexually-active women ages 16-24 at least annually. Women age 25 and older at increased risk.	*Women		Women at higher risk										
Cholesterol Screening Men ages 25-35 & women over age 20 who are at increased risk for heart disease. All men aged 35 and older.		Men at higher risk			All Men								
		Women at higher risk											
Colorectal Cancer Screening Fecal Occult Blood Test (FOBT) Annually -OR- Sigmoidoscopy every 5 years, with high-sensitivity FOBT every 3 years -OR- Screening colonoscopy every 10 years							Both Men & Women						
Depression Screening Discuss life stress with your doctor. Getting help is the best thing you can do.	Both Men & Women												
Dental Care Take care of your teeth and gums. Get a routine dental visit at least once a year.	Both Men & Women												
Diabetes (Type 2) Screening You can do a lot to prevent or delay getting Type 2 diabetes.	Every year for both Men & Women												
Hepatitis C Screening	Men & Women at risk for infection and all adults born between 1945 and 1965												
HIV Screening	Both Men & Women										Those at high risk		
Osteoporosis Screening Keep your bones strong. People at increased risk need bone density testing.								Women at higher risk			All Women		

References: US Preventive Services Task Force • JNC Express: Prevention, Detection Evaluation and Treatment of High Blood Pressure • National Heart, Lung, and Blood Institute • www.cdc.gov/STD/chlamydia

Exams, Screenings and Immunizations

For Adults

Every year, adults need to receive an annual check-up from their doctor. Depending on your age and gender, you may need certain screenings and even immunizations.

Women's Health Preventive Care

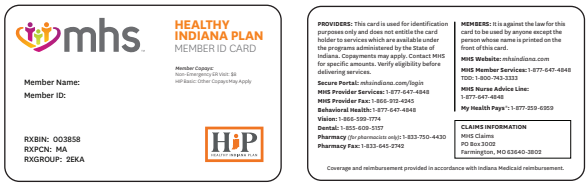
Women need certain health tests men don't need. These tests are simple screenings that can make a big difference. All women should talk to their doctor about getting preventive care screenings such as Pap tests, chlamydia tests and mammograms. Women's preventive health screenings and getting birth control (family planning) are self-referral services. That means you can see a doctor other than your MHS doctor. You do not have to get a referral from your doctor, but you must visit an Indiana Medicaid network provider.

Always Show Your MHS Member ID Card

Bring your HIP member ID card each time you get medical care or go to the pharmacy. If you cannot verify Medicaid eligibility, you may have to pay for your care. If you do not have your ID card at the time of your appointment, you can still be seen by the doctor once your Medicaid eligibility is verified. Medicaid eligibility can be verified if you can provide one of the following for the individual receiving services:

- Member ID
- Social Security number and date of birth
- First and last name

If you receive a bill for covered services or are told to file a claim, please contact MHS Member Services right away at 1-877-647-4848. Your card will look like this:



HIP Basic, Plus, State Plan and Maternity

Secondary Insurance

You must also show your identification cards for any other health insurance you have each time you get care. Please let MHS know if you have other health insurance. If you cancel or lose your other health insurance, please remember to speak with a state caseworker to update your information.

Preventive Services for HIP Discounts

MHS wants you to get your needed preventive care. This is why preventive services are not paid from your POWER Account. In addition, managing your account and getting preventive care can reduce your next year's contribution. If your healthcare expenses through the year do not use all of the funds in your POWER Account, you may rollover the portion of the remaining balance that you contributed towards your next year of HIP coverage. This is called Member Rollover. You can also have your Member Rollover doubled if you get certain preventive services. By managing your account wisely and getting recommended preventive care, you can reduce or eliminate your required contributions next year with rollover.

For example, if you paid $240 total in contributions for your benefit year ($20/month), you paid 10% of the annual POWER Account. If you end the year with $1,000 remaining in your POWER Account, you get to rollover 10% of that to next year,
or $100.

If you receive preventive services, you can double that Member Rollover, and get $200 towards your contribution for your next benefit year. That $200 would reduce the amount you pay in POWER Account contributions in the next benefit year.

Any preventive service will qualify you to double your rollover account. Here are some examples:

SERVICE	APPLICABLE APPLICATION
Annual Physical	All
Blood Glucose Screen	All, disease-specific
Tetanus-Diphtheria Screen	All
Cholesterol Testing	Males over age 35, females over age 45
Mammogram	Females over age 50
Pap Smear	Females between 21-50 years of age

*Check with your doctor about specific recommendations based on your age and medical history.

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.

Your HIP Plan – The Differences

Depending on your income status, pregnancy status, and if you pay a monthly contribution, you may be in one of several HIP plans, including **HIP Plus**, **HIP Basic**, **HIP State Plan** and **HIP Maternity**. Your benefits may vary, depending on what plan you are in. If you're not sure which plan you're in, please call MHS Member Services at 1-877-647-4848.

HIP Plus

HIP Plus is the plan for the best value! You get the most benefits at a low, predictable monthly cost.

HIP Plus benefits include all of the required essential health benefits. In addition, it includes dental, vision and chiropractic services, plus services for bariatric surgery and temporomandibular joint disorders (TMJ). And, there are fewer limits on annual visits to see physical, speech and occupational therapists.

HIP Plus members pay an affordable monthly contribution, based on their income, called a POWER Account Contribution (PAC). For married couples enrolled in HIP Plus, the contribution amount will be split. Invoices are sent by mail to your home address. If you are eligible for the Healthy Indiana Plan (HIP) and you are a tobacco user, you may have an increased PAC in your second year of coverage. Learn more about the surcharge and how MHS can help you quit in the Care and Case Management Programs section of this handbook. A tobacco user is a person who uses tobacco products at least four (4) times a week on average in the last six (6) months. Tobacco includes chewing tobacco, cigarettes, cigars, pipes, vapes, hookah and snuff. If you feel you were mistakenly marked as a tobacco user or you have stopped using tobacco, please contact MHS Member Services at 877-647-4848.

HIP Plus Copay Amounts

Paying a monthly contribution to stay in HIP Plus can be cheaper than HIP Basic, because you do not have to pay a copay at the time of service for many services:

Outpatient Services – Including Doctor's Office Visits	$0
Inpatient Services – Including Hospital Stays	$0
Preferred Drugs	$0
Non-Preferred Drugs	$0
Non-Emergency ER visit	$8

Late Payments & Disenrollment

Monthly contributions are due by the due date listed on the monthly invoice. After that due date, the member has 60 days to make their payment before they lose HIP Plus coverage.

HIP Plus to HIP Basic

Members who lose HIP Plus coverage due to non-payment, and have a household income less than or equal to 100 percent of the federal poverty level (FPL) may move from HIP Plus benefits to HIP Basic benefits, automatically. Members who are above the 100 percent FPL may lose their coverage completely.

HIP Basic

HIP Basic benefits include all of the required essential health benefits. It does not include dental, vision or chiropractic services, or services for bariatric surgery and temporomandibular joint disorders (TMJ). And, there are more limits on annual visits to see physical, speech and occupational therapists.

HIP Basic Copay Amounts

HIP Basic members do not have a simple, predictable monthly contribution. Instead you are responsible for paying for copayments at the time of service. Because of this, the HIP Basic plan could be more expensive than paying a monthly contribution to stay in HIP Plus.

Outpatient Services – Including Doctor's Office Visits	$4
Inpatient Services – Including Hospital Stays	$75
Preferred Drugs	$4
Non-Preferred Drugs	$8
Non-Emergency ER visit	$8

Annual Redetermination

If you are currently in the HIP Basic or HIP State Basic plans, make sure to re-enroll in HIP Plus / HIP State Plan Plus at the start of your next eligibility period. Pay your monthly contributions on time to stay in HIP Plus / HIP State Plan Plus!

Did you know you can use My Health Pays® Rewards to pay your monthly payment? See page 40 to find out how to earn rewards!

HIP State Plan

HIP State Plan benefits include all of the required essential health benefits, and some enhanced benefits such as dental, vision and chiropractic services. HIP State Plan members may or may not have copays, depending on if they are in the HIP State Plan Plus or HIP State Plan Basic.

HIP State Plan Plus Costs

HIP State Plan Plus members pay an affordable monthly contribution, based on their income. If you do not pay your monthly contribution on time, you may be moved to HIP State Plan Basic. The HIP State Plan Plus members pay the same copay amounts as HIP Plus members:

Outpatient Services – Including Doctor's Office Visits	$0
Inpatient Services – Including Hospital Stays	$0
Preferred Drugs	$0
Non-Preferred Drugs	$0
Non-Emergency ER visit	$8

If you are eligible for the Healthy Indiana Plan (HIP) and you are a tobacco user, you may have an increased POWER Account Contribution in your second year of coverage. Learn more about the surcharge and how MHS can help you quit in the Care and Case Management Programs section of this handbook. Tobacco includes chewing tobacco, cigarettes, cigars, pipes, vapes, hookah and snuff. If you feel you were mistakenly marked as a tobacco user or you have stopped using tobacco, please contact MHS Member Services at 877-647-4848. A tobacco user is a person who uses tobacco products at least four (4) times a week on average in the last six (6) months. Tobacco includes chewing tobacco, cigarettes, cigars, pipes, vapes, hookah and snuff. If you feel you were mistakenly marked as a tobacco user or you have stopped using tobacco, please contact MHS Member Services at 877-647-4848.

HIP State Plan Basic Costs

HIP Basic members do not have a simple, predictable monthly contribution. Instead they are responsible for paying for copayments at the time of service. Because of this, the HIP Basic plan could be more expensive than paying a monthly contribution to stay in HIP State Plan Plus. The HIP State Plan Basic members pay the same copay amounts as HIP Basic members:

Outpatient Services – Including Doctor's Office Visits	$4
Inpatient Services – Including Hospital Stays	$75
Preferred Drugs	$4
Non-Preferred Drugs	$8
Non-Emergency ER visit	$8

Cost Sharing, Copayments and Contributions. What you need to know.

Cost sharing means that you and MHS work together to pay for your health care services. MHS pays most of the costs. Cost sharing can include copayments and monthly POWER Account Contributions (PAC). MHS keeps track of your costs for you.

Your cost sharing may change throughout the year. When a family's total cost-sharing expenditures come close to exceeding five percent (5%) of the family's income in the quarterly period, MHS is required to notify the State. When we find that you have met the 5% cost share limit, HIP Basic members will not have any copays and HIP Plus members will see their POWER Account contributions (PAC) reduced to $1.00 or $1.50 for tobacco users, for the remainder of the calendar quarter.

Some services are exempt from copays for all HIP members. These services include:
- Emergency Services
- Family Planning Services
- Pregnancy related services
- Preventive care services

There are also groups of members who are exempt from cost sharing. They will not have any copays or monthly contributions. These groups include:
- American Indian/Alaska Native – verified member of a federally recognized tribe
- Pregnant members (12 months postpartum coverage)

MHS is your partner in care. We are here to help you understand how your coverage works. Learn about cost sharing and more online at mhsindiana.com.

Are you pregnant? Tell us right away!

All you need to do is complete a Notification of Pregnancy survey. Get started:

- Sign into your Member Portal account and then fill out the Notification of Pregnancy form.
- Or, call an OB Nurse at 1-877-647-4848, Extension 20309 to complete it over the phone.

Pregnant HIP members' benefits change so that:

- You will not pay a monthly POWER Account contribution (PAC) while pregnant.
- You will not have copays for healthcare services while pregnant.
- You may receive additional benefits, such as medical transportation, while pregnant.
- You could qualify for an additional $80 dollars of My Health Pays® rewards.

These extra benefits make it easier to see your doctor so you can get important prenatal (pregnancy) care. These services will begin the first day of the month after you've reported your pregnancy to MHS and the DFR.

Pregnancy benefits will end 12 months after your pregnancy ends. To avoid a gap in coverage, please tell MHS and the DFR as soon as your pregnancy ends. Login to your portal account to complete your "End of Pregnancy" form.

Medically Frail

Individuals with complex medical or behavioral health conditions, called Medically Frail, may be eligible to receive HIP State Plan benefits.

An individual is Medically Frail if he or she has been determined to have one or more of the following:
- Disabling mental disorders (including serious mental illness)
- Chronic substance use disorders
- Serious and complex medical conditions
- A physical, intellectual or developmental disability that significantly impairs the ability to perform one or more activities of daily living like bathing, dressing or eating.
- A disability determination from the Social Security Administration
- Has been confirmed HIV positive by the Indiana Department of Health

There are multiple ways to be identified as Medically Frail including:
- Through claims review
- By self-report
- At the request of your provider

If you would like to report Medically Frail status, call MHS Member Services at 1-877-647-4848. MHS is required to verify your request for Medically Frail status by having you complete a Health Needs Screening and reviewing the medical records from your doctor.

If MHS confirms your status as Medically Frail, you will receive HIP State Plan benefits. You have the right to appeal if you do not agree with MHS' Medically Frail decision.

Your POWER Account

The first $2,500 of medical costs for your HIP benefits are paid from a special savings account called a **Personal Wellness and Responsibility (POWER)** Account. Every HIP member has their own POWER Account. The state pays most of the $2,500, and if you are in **HIP Plus** or **HIP State Plan Plus**, you are responsible for paying a portion. The portion is your monthly contribution to your POWER Account and is based on your income.

FOR EXAMPLE:	
Your contribution:	**$180 ($15 each month for 12 months)**
+ The state's portion:	**$2,320**
= Total POWER Account funds:	**$2,500**

Your POWER Account is debited each time you get healthcare services. If your yearly healthcare expenses are more than $2,500, the first $2,500 is covered by your POWER account, and expenses for additional health services over the $2,500 are fully covered at no additional cost to you. Yearly preventative services are covered at no cost to you. The POWER Account can only be used to pay for covered services. You are responsible for paying for services not covered under HIP. You cannot use your POWER account card to pay for copays, prescriptions, or ER visits. For additional information regarding your POWER account, please visit us on our website, HIP POWER Account.

Your POWER Account Statement
MHS will give you a monthly statement showing you:
- The amount you have paid so far in contributions towards your POWER Account.
- The amount you have spent so far on medical services from your POWER Account.

You can access your statement through your member account at mhsindiana.com.

Paying Your Monthly Contribution
MHS gives you easy ways to pay your monthly contribution:
- Cash/Check
- Electronic Funds Transfer through Automated Clearing House (ACH)
- Debit/Credit
- Payment by Phone: 1-877-647-4848. Monday through Friday from 8 am to 8 pm
- Payroll deductions by your employer
- Money Order
- Moneygram: Visit a MoneyGram retailer like CVS/pharmacy or Walmart. Find a MoneyGram location at 1-800-926-9400 or by visiting www.moneygram.com.
- With your My Health Pays® by calling MHS Member Services or by logging into your secure portal and clicking "View Ways to Make a Payment"
- Employer, Non-Profit & Other Contributions (More information on page 21)

You can pay using a debit or credit card online at mhsindiana.com. Or, you can get paperwork you need to set up auto-deduction and electronic fund transfers from your personal bank account at mhsindiana.com. Click on For Members > Healthy Indiana Plan > Member Resources > Member Forms.

Potential Payment Problems
If you set up automatic payments, check to be sure the first automatic payment will start before you stop making one-time payments.

MHS will notify you if your payment cannot be processed so you can find another way to pay or help fix the problem. However, MHS has the right to charge a standard fee of $25 for returned checks or other non-sufficient fund rejections.

Some kinds of payment methods may not show in your account right away. But, if you get a late payment notice from MHS after you already paid, please call MHS Member Services at 1-877-647-4848 to make sure your payment has gone through correctly. Include payment voucher from the bottom of your invoice with your payment, check or money order or fill out the coupon with your credit or debit card information. Please write your check out to Managed Health Services or MHS.

IMPORTANT: If you mail a payment close to the end of the month, it may not be processed in time. Please use one of the other options - phone, online or in person at our office or MoneyGram location.

Mail payment to: MHS, PO Box 2983, Omaha, NE 68103

Did you know you can use My Health Pays® Rewards to pay your monthly payment?
See page 40 to find out how to earn rewards!

Employer, Non-Profit & Other Contributions
Your employer, a non-profit organization or a friend or family member are allowed to pay some or all of your contribution. This is up to your employer or the organization and is not a requirement. The payment can be one-time or monthly. You can get a copy of the contribution form at mhsindiana.com. Click on For Members > Healthy Indiana Plan > Member Resources > Member Forms.

You are always responsible for your full payment. If your employer or the organization does not pay their agreed amount, MHS will send you a letter to let you know. You then have 60 more days to pay that amount after the past due date. If not paid by the additional 60 days, MHS considers the payment late, and depending on your benefit program, you could be disenrolled from HIP.

Your Monthly Contribution Amount
HIP Plus members pay an affordable monthly contribution, based on their income. The following table shows these amounts. If you are eligible for HIP and you are a tobacco user, you may have an increased POWER Account contribution (PAC). Tobacco users will have a 50% surcharge added to their required PAC amounts if they do not cease use after a full calendar year has passed.

Tier	Monthly PAC Single Individual	Monthly PAC per Spouse	PAC with Tobacco Surcharge	Spouse PAC when one has tobacco surcharge	Spouse PAC when both have tobacco surcharge (each)
1	$1	$1	$1.50	$1 & $1.50	$1.50
2	$5	$2.50	$7.50	$2.50 & $3.75	$3.75
3	$10	$5	$15	$5 & $7.50	$7.50
4	$15	$7.50	$22.50	$7.50 & $11.25	$11.25
5	$20	$10	$30	$10 & $15	$15

A tobacco user is a person who uses tobacco products at least four (4) times a week on average in the last six (6) months.

The state determines your monthly contribution amount. It is based on your income and family size. There are two ways to request a change in your payment amount:

1) If you have a "qualifying event": A job loss or other change in income.
2) If you have a change in family size: A death, divorce, birth or a family member moving out of the household. You can request a change in payment amount due to a change in family size as many times as needed during your benefit year.

To start the request, call 1-800-403-0864 or go to FSSABenefits.IN.gov and create an account or click "Report a Change."

MHS has behavioral health case managers who help members with special healthcare needs by working together with you and your behavioral health doctor to make a plan of care.

If you are having one of the following problems, please call our MHS Member Services department at 1-877-647-4848:
- You are worried about substance abuse or mental health issues
- You are sad or feel you need help
- You need names of therapists or doctors
- You need help to find resources in your community for mental health
- You don't understand your mental health benefits
- You need mental health services and you are not near your home

Crisis Support

If you are in crisis and need support, you can:
- Text MHS to 741741
- Call 1-877-647-4848 and press *

It's free, confidential and available 24/7. If you don't want to use MHS, or if someone in your household is not eligible with MHS, you can use the National Suicide Prevention Lifeline. Call, text or chat with trained counselors using 988.

Covered Behavioral Health Services

- Diagnostic services
- Second opinions
- Crisis intervention
- Psychological testing
- Inpatient and outpatient
- Intensive outpatient programs
- Addiction counseling and treatment
- Partial hospitalization
- Residential Substance Use Disorder Treatment
- Medication Assisted Treatment (MAT), including Opioid Treatment Programs (OTP)

Long-term care, home and community-based waiver services, state psychiatric facility services and psychiatric residential treatment facility are not covered by Healthy Indiana Plan (HIP).

Behavioral Health Programs

- **Pregnancy and Post-Partum Care**: If you are pregnant or just had a baby, you will get a survey and information about depression. If your survey shows you may be experiencing signs of depression, MHS will contact you. It's important you get the help you need to have a positive pregnancy and a healthy baby.

- **Medicaid Rehabilitation Option (MRO) and Other Services**: Coverage of MRO and psychiatric residential treatment facility services is managed directly by the state of Indiana. MHS will work with the State and your doctors to coordinate this care.

- **Health Coaching Program**: Designed to help individuals diagnosed with anxiety, depression, ADHD, substance use disorder, perinatal substance use disorder or perinatal depression by giving them the tools to reach their health and wellness goals. When it comes to your health and well-being, it is important to understand mental health is part of overall health. We will work with you and your care team to make sure you have everything you need to feel your best again. Please contact us if you are interested in joining this program.
  - MHS's Health Coaching programs are designed to engage and empower members living with a both medical conditions and certain behavioral health conditions. The goal of these programs is to help you have less symptoms, feel well, and enjoy a good quality of life.
- **Complex Care Management Programs**: Complex care management is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.
  - **Autism/Pervasive Developmental Disease Program (Autism Spectrum Disorders)**: MHS' program helps you get needed care and treatment to improve social, communication, behavioral, medical and other problems that may be present. We want to help you learn more about autism and how to work toward self-care management. We also work to help obtain other available services that can improve learning and other skills.
  - **Hospital Admission Follow-Up:** If you have been in the hospital for a mental health or substance abuse reason, MHS can help you. MHS wants you to be safe once you go home. MHS will help make sure you go to your follow-up appointments and take all needed medicines as directed by the hospital.

For more information on specialized health programs, please go to our website.

Access & Availability Standards

Members shall be able to receive timely access to medically necessary behavioral health services. Providers are required to offer timely access to behavioral health screening, assessment, referral and treatment services, including outpatient services as well as inpatient psychiatric hospital services, inpatient drug and alcohol detoxification and inpatient drug and alcohol rehabilitation, with the exception of treatment rendered in a State Hospital.

All outpatient mental health services shall be delivered by licensed psychiatrists and health service provider in psychology (HSPP), or an advanced practice nurse or person holding a master's degree in social work, marital and family therapy or mental health counseling.

Dental Benefits

Dental benefits are provided for members in **HIP Plus:**, **HIP State Plan,** **HIP Basic (ages 19 & 20 only)** and **HIP Maternity**. Some dental services must be approved in advance by MHS, including dentures and dental surgery. Your dentist can help you get approval.
Benefits include:

HIP Plus:
- Oral exams: One every six months per member
- Teeth cleanings: One every six months per member
- Emergency oral exams
- Bite-wing x-rays: One complete bitewing x-ray series per 12 months
- Comprehensive x-rays: One set per 60 months
- Minor restorative services, such as fillings: Four per person per 12 months
- Major restorative services, such as prefabricated crowns: One per person per benefit year. One per tooth per lifetime.

HIP State Plan (Plus and Basic):
- Oral exams: One every six months per member
- Teeth cleanings: One every six months per member
- Emergency oral exams
- Bite-wing x-rays: One complete bitewing x-ray series per 12 months
- Comprehensive x-rays: Complete set per 36 months
- Extractions - surgical removal of erupted or impacted tooth: No limit.
- Dentures and denture repairs

HIP Basic (Ages 19 & 20 only):
- Oral exams: One every six months per member
- Teeth cleanings: One every six months per member
- Emergency oral exams
- Bite-wing x-rays: One complete bitewing x-ray series per 12 months
- Comprehensive x-rays: Complete set once per 36 months

HIP Maternity:
- Oral exams: One every six months per member
- Teeth cleanings: One every six months per member
- Emergency oral exams
- Bite-wing x-rays: One complete bitewing x-ray series per 12 months
- Comprehensive x-rays: Complete set one per 36 months
- Extractions - surgical removal of erupted or impacted tooth: No limit
- Dentures and denture repairs

Find a Dentist
Go online to mhsindiana.com/find-a-provider, or call MHS Member Services at 1-877-647-4848 (TTY: 1-800-743-3333), for assistance.

Your Dental Visit

Your Health History
Since oral health is linked to general health, your visit will likely start with your health history. Tell your dental provider about any health problems you have or medicines you take. This includes any over-the-counter medicines, herbs, or supplements you take, as well as recreational drugs you use. You may also be asked about your daily tooth and gum care. Tell your dental provider if you grind your teeth or often breathe through your mouth. You should also bring up any oral health issues that concern you.

Your Dental Evaluation
Your dentist or dental hygienist may start by screening for oral cancer. This involves feeling your neck and throat and looking inside your mouth. Then your dental provider will:

- **Examine your teeth.** If you have any tooth decay, it will be marked on your dental record. Notes will be made about any restorations, like fillings or cracked teeth.

- **Examine your gums.** A probe is used to measure any pockets (areas where the gum has separated from the tooth) and gum recession. Your dentist or dental hygienist will also evaluate any bleeding that occurs. (Bleeding gums can be a sign of gum disease.)
- **Take X-rays and impressions** (pictures and molds of the teeth), if needed. These will be put in your record so your dentist or dental hygienist can refer to them at your next visit. This helps keep track of any changes to your mouth over time.

Cleaning and More

Depending on what your dental provider finds, the rest of your visit may include:

- A cleaning to help prevent gum disease. Your dental provider will clean below the gumline, where your toothbrush and floss can't reach.
- A cosmetic polishing to remove stains on the surfaces of your teeth (if needed).
- Further evaluation and treatment for any problems your dental provider finds. You may be referred to a specialist.
- Instruction for giving your teeth and gums the best care at home.

Vision Benefits

Vision benefits are provided for members in the following plans:
HIP Plus, **HIP State Plan**, **HIP Maternity, HIP Basic (ages 19 & 20 only)**

Find an Eye Doctor

- Go online to visionbenefits.envolvehealth.com
- Click on "Find a Provider"
- Enter your zip code
- Choose "MHS Healthy Indiana Plan HIP" as your "HealthPlan"
- Or, contact Member Services at 1-877-647-4848 (TTY: 1-800-743-3333), for assistance.

Covered Routine Care

- Members ages 19 and 20:
  - One routine vision exam every year
  - New eyeglasses after your exam if your vision has changed significantly since your last pair, or as determined by your doctor.

- Members ages 21 and older:
  - One routine vision exam every two years
  - New eyeglasses after your exam if your vision has changed significantly since your last pair, or as determined by your doctor. If your vision has not changed, then you are covered for new eyeglasses once every two years.

Additional Coverage

- Replacement eyeglasses and/or frames for lost, damaged, or stolen frames, as determined by your doctor.
- Contact lenses are covered if you have a medical reason you cannot wear glasses, as determined by your doctor.
- Medically necessary eye tests and treatment for members with eye disease or other diseases that affect the eyes.
- Vision surgery and training therapies are covered if medically necessary, as determined by your doctor.

Enhanced Vision Benefits

Members may opt out of the standard eyewear benefit and receive $75 toward contact lenses and lens fitting.

Chiropractic Benefits

Chiropractic benefits are provided for members in the following plans: **HIP Plus**, **HIP State Plan** and **HIP Maternity**.

Find a Chiropractor
- Go online to mhsindiana.com
- Click on "Find a provider" at the top of the page
- Choose "Start your search"
- Enter your zip code and choose your network
- Search for Chiropractors under Detailed Search → Specialty → Chiropractor

Covered Benefits
- Self-referral – provider referral is not required
- No prior authorization is needed
- Coverage available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic.

Pharmacy Benefits

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 an in-network pharmacy, including mail-order pharmacies. Find a pharmacy online at mhsindiana.com/find-a-provider.

Covered Prescriptions/Preferred Drug List (PDL)
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.

Your pharmacy benefit has a Preferred Drug List (PDL). The PDL shows the drugs that are covered. A team of doctors and pharmacists update this list four times a year. Updating this list makes sure that 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 a link to your PDL and OTC drug formulary on the MHS website at mhsindiana.com. Click on For Members > Healthy Indiana Plan > Benefits & Services > Pharmacy.

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

Generic and Preferred Drugs

Your pharmacist will give you generic drugs when your doctor has approved 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."

Generic and preferred drugs must be used when available for your medical condition unless your doctor provides a medical reason you must use a different drug.

Prior Authorization for Drugs

Some drugs may need prior authorization from MHS. If you may need a drug that requires prior authorization, your doctor will need to provide information about your health in order for a decision to be made about whether or not MHS can pay for the drug. 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 be approved through MHS before MHS will cover them. The list of specialty drugs is available on our website. 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 before you get the drug
- You are getting more of the drug than is usually prescribed
- There are other drugs that should be tried first

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), and your doctor will be notified of the decision.

You or your prescriber can download copies of our prior authorization forms (including specialty forms) at mhsindiana.com.

When and Where to Go for Care

It's important to visit the right doctor for the right kind of care. You might hear the words Primary Medical Provider (PMP), practitioner, physician and provider from MHS. All these titles mean doctor or a facility where you get healthcare services. Search for the healthcare service you need by using our find a provider (FAP) tool.

Your Primary Medical Provider (PMP): You should visit your PMP for sick visits, regular checkups, immunizations (shots), prescriptions, referrals to specialists and hospitals, and pregnancy care.

Specialists: A specialist is a doctor who works in one healthcare area. For example, a doctor who only works with the heart (a cardiologist) is a specialist. In order to visit a specialist, you need to get a referral from your PMP, first.

Walk-In Clinic/Urgent Care Facility: Walk-in clinics provide high-quality care when quick medical attention is needed for non-life-threatening conditions.

Emergency Room (ER): Emergency care is there for you when you feel you have a life-threatening medical emergency. If you are not sure if you're having an emergency, please call your PMP. If you cannot reach your PMP's office, you can call MHS' nurse phone line. If either your doctor or the MHS 24 hour nurse advice line advises you to go to the ER, then you will not be charged a copay for your ER visit.

You Deserve a Medical Home – A Primary Medical Provider (PMP)

You deserve a successful medical home, where:

- You and your doctor can build a trusting relationship.
- You have a place you can always go to for sick visits and regular check-ups.
- You feel that your doctor and his or her staff care for you and are responsible for your healthcare.

Visit your PMP for sick visits, regular checkups, immunizations (shots), prescriptions, referrals to specialists and hospitals, and pregnancy care. Your PMP will work to know your medical history, take the time to listen to your concerns, explain things to you in a way you can understand, and work with you to keep you healthy.

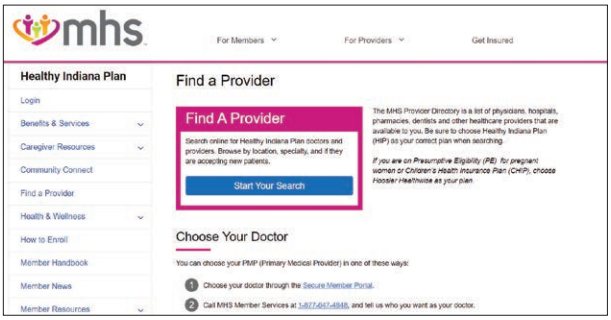
Always call your doctor to cancel appointments. If you do not cancel your appointments, and if you miss more than three appointments, your doctor may have the right to ask MHS to move you to a different doctor.

Choose or Change Your MHS Doctor

Whether you are choosing your doctor for the first time or changing your doctor, the process is easy and fast. You can change your doctor at any time. New members need to choose their doctor within the first 30 days of becoming an MHS member. If you do not choose a doctor, you are assigned to a doctor on the 30th day of your membership.

First, find a list of doctors in your area:

- Go online at https://www.mhsindiana.com/members/hip/find-a-provider.html
- Or call MHS Member Services at 1-877-647-4848 and ask for a list



Last, tell us! You can tell us one of two ways:

1) Choose your doctor through the Secure Member Portal at mhsindiana.com/login.
   New members can earn a reward by choosing their PMP this way.

2) Call MHS Member Services at 1-877-647-4848, and tell us who you want as your doctor.

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

How Long it May Take to Schedule an Appointment

MHS wants you to get care when you need it. We work hard to build a network of providers that works for you, and our network keeps growing. But, sometimes you will still need to wait to see a provider. We use the State's standards for appointment wait times. Please call MHS Member Services if you have a question or concern about the appointment wait time at your doctor's office. Here is how long it should take to schedule an appointment with your doctor:

APPOINTMENT TYPE	APPOINTMENT SCHEDULED BY:
Urgent care or sick visits	Scheduled within one day (24 hours)
Non-urgent visits	Scheduled within three days (72 hours)
Adult preventive exams / annual well-care visits	Scheduled within three months
New pregnancy visit	Scheduled within one month
Child preventive exams / well-child check-ups	Scheduled within one month
Exams for children with special needs	Scheduled within one month

When you are in the doctor's office, you should only have to wait up to one hour for your scheduled appointment.

Get the Most from Your Doctor Visit

- Arrive on time
- Bring your insurance card and photo ID
- Turn off your cell phones and other electronic devices
- Write down a list of questions to ask the doctor
- Bring your medical and shot records and any medicine you are currently taking
- Describe symptoms and complaints
- Ask questions and take notes during each visit
- Discuss next steps for your care plan with the doctor
- Schedule follow-up visits and any yearly check-ups
- Learn how to Maximize Your Health on our website. These health and financial literacy resources will help you make the most of your health insurance.

Specialists

A specialist is a doctor who works in one healthcare area. For example, a doctor who only works with the heart (a cardiologist) is a specialist. Your doctor may refer you to see a specialist if needed. Normally, your doctor will refer you to another MHS network doctor unless your medical condition could be better treated by someone other than an MHS network doctor.

When you visit a specialist, please make sure the specialist has the correct contact information for your doctor. Your specialist will send a report to your doctor that details your care plan.

Self-Referral Services

MHS allows for some self-referral specialist visits. A self-referral means you do not have to get a referral from your doctor. For a list of self-referral services for Healthy Indiana Plan, see page 13.

PMP or Specialist Office Changes

Sometimes you can no longer be assigned to a doctor or specialist because the doctor is moving locations, moving to a new health plan (no longer on the MHS plan), or because the doctor is no longer accepting patients of your age or gender. If this change happens with a doctor you are currently seeing, MHS will send you a letter to let you know. The letter will explain what options you have and if you can choose to stay with your doctor.

You may continue to see your doctor if they have left the network through the current period of active treatment, or for up to 90 calendar days, whichever is less, if undergoing active treatment for a chronic or acute condition. If you are pregnant and already in your second or third trimester you may continue with your doctor for up to six (6) weeks after delivery.

Continuity of Care

We are here to help our members get continuing care and coordination of medically necessary health care when they join/leave MHS. If you want to know if continuity of care is for you, or you would like a copy of our transition of care policy, please call Member Services.

Walk-In & Urgent Care Clinics

(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 have an after-hours phone line. If you cannot reach your doctor, you can call the free MHS 24 hour 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.

Walk-In Clinics
Walk-in clinics provide high-quality care when quick medical attention is needed for non-life-threatening conditions such as:

- Sprains, strains, fractures and cuts
- Flu and cold symptoms
- Work-related illness or injuries
- Minor burns
- Stings or bites
- Earache, sore throat and fever

Urgent Care Clinics
Many clinics are open later in the evening and have extended weekend hours. Urgent care clinics help patients get care without waiting in the emergency room of their local hospital. These clinics may use physician assistants and nurse practitioners to treat you. Physician assistants and nurse practitioners are trained and supervised in providing medical care. They perform many of the routine services physicians usually provide. They can take medical histories, perform physicals and exams, order medications, lab tests and X-rays, and teach patients how to stay healthy.

Visit mhsindiana.com/find-a-provider to find a clinic near you.

Teladoc Virtual Health
Teladoc is an easy way for MHS members to get telehealth services. You can get help for non-emergency medical issues 24 hours a day. All providers are in the MHS network.

Get medical advice, a diagnosis or a prescription by video or phone.

Telehealth services are available when you need them using Teladoc. You can make an appointment for a time that works with your schedule.

Set up and activate your Teladoc account, so it's ready when you need it. Visit: Teladoc.com/mhsindiana.
For questions, call 1-800-835-2362 (TTY: 711).

Emergency Room: Know When to Go

Only go to the Emergency Room if you have a life- threatening injury or illness. You have other options that may have a shorter wait time.

Other ways you can get care and support for non-life-threatening injuries or illness include:
- Primary Medical Provider (PMP)
- Free 24/7 Nurse Advice Line
- Urgent Care Centers for in network options
- Telehealth

When to Go to the Emergency Room

- Broken bones
- Gun or knife wounds
- Bleeding that will not stop
- You are pregnant, and either in labor or bleeding
- Severe chest pain or heart attack
- Drug overdose
- Poisoning
- Bad burns
- 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.

When NOT to Go to the Emergency Room

- **Flu, colds, sore throats and earaches**
- **A sprain or strain**
- **A cut or scrape not requiring stitches**
- **To get more medicine or have a prescription refilled**
- **Diaper rash**

Emergency Care Coverage
Emergency room visits do not need approval from your doctor or by MHS. However, if you go to the emergency room for a non-emergency health condition, you will have a copay of $8. If your are pregnant or identified as an American Indian or an Alaska Native during the eligibility process, you do not have a copay.

If you are unsure if you should seek medical attention from an emergency room for a non-life threatening event, call your doctor's office first. If you cannot get a hold of your doctor, you can call the MHS nurse advice line.

If either your doctor or the nurse advice line tells you to go to the emergency room, your visit will be covered in full. You will not pay an emergency room copay.

Emergency Room Wait Times
In an emergency room, life-threatening emergencies are seen first. If you go to the emergency room for an injury or illness that is not life-threatening, you may have to wait for several hours to get seen. It is very important you see your family doctor or visit an urgent care center for non-emergencies.

Be Prepared Before an Emergency
Make sure you know the location and number of the closest emergency room to you. You can find one near you by using our "Find a Provider" search at mhsindiana.com/find-a-provider, or 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. You have a right to use any hospital or other emergency setting for emergency care.

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.

Post-Stabilization Care
Post-stabilization is a covered service you get after emergency care. This is care you receive after you are stabilized so your condition stays stable. When you visit the emergency room, the doctors and nurses must examine you and make sure you are well enough before they can allow you to leave. The doctor may decide you need other tests or services after you are stable but still at the hospital, and the doctor can call MHS to request other tests or services.

Coverage for Care Outside of Indiana

Walk-In or Urgent Care

If you are out of the state and need to go to a walk-in or urgent care clinic for a problem that is not life-threatening, you must call your MHS doctor or the MHS nurse advice line at 1-877-647-4848 to get approval before you go. Otherwise, you may have to pay for the services you get at the clinic.

Emergency Care

If you are outside of Indiana and have a life-threatening emergency, go to the nearest emergency room. Emergency room coverage for care outside of Indiana is covered. Learn more about emergency care on page 34.

Care From Out-of-Plan Doctors

Out-of-plan 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 responsible 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.

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
- MHS authorized the out-of-plan service

Self-Referral Services

Please refer to Page 13.

American Indian and Alaskan Native Health Care Providers

Any American Indian/Alaska Native (AI/AN) member who is eligible to receive services from a participating Indian healthcare provider can choose to receive covered services from that Indian healthcare provider, and if that Indian healthcare provider participates in the network as a PMP, can choose that Indian healthcare provider as his or her PMP, as long as that Indian healthcare provider has the capacity to provide the services.

Health Management Programs

These programs are designed to improve the health of our members through education and personal assistance by our professional staff.Call us today to learn how you can access these customized services, tailored just for you. MHS has case managers who are trained to help our members with their health conditions. A case manager works with members and their family, providers, and community groups to set goals that will help you improve your health. A case manager can help you understand your benefits and treatment options and can assist with emergency housing and utility needs and other services such as rides to the doctor, food, and more.

If you have or are at risk for having one of the following health conditions listed, please call so we can tell you more about our programs and help you enroll. Take the first step towards better health — call MHS Member Services at 1-877-647-4848 today. Plus, you can earn a My Health Pays® reward by participating in certain programs!

Medical Case Management Programs

- **Chronic Kidney Disease (CKD) Program**: CKD is a disease where the kidneys become less able to clean waste and extra fluid out of the blood. MHS helps you to manage risks for CKD, such as diabetes and high blood pressure. This may help keep you out of kidney replacement therapy. Our team will help you learn how to improve your diet and help you get services for the disease and its causes.
- **Congestive Heart Failure (CHF) Program**: CHF is a disease that occurs when your heart is too weak to pump blood. Our CHF program emphasizes effective medication management, reducing your risk of heart attacks, strokes, ER visits and hospitalizations — helping you maintain a healthier, more active life.
- **Coronary Artery Disease (CAD) Program**: CAD happens when a substance called plaque builds up in the arteries that supply blood to the heart (called coronary arteries). Our CAD program helps you to deal with the effects of CAD, such as chest pains, physical limitations and high cholesterol. We do this through medication (drug) management, lifestyle changes, diet and other ways to cope.
- **Diabetes ("Sugar") Program**: Diabetes is also known as "sugar." Type 1 diabetes is a disease where your body can no longer make insulin. Type 2 diabetes is a disease where your body cells are less sensitive to your insulin. Both types can cause high blood sugar levels. Please contact us if you have diabetes.
- **Enhanced Asthma Management and Chronic Obstructive Pulmonary Disorder (COPD) Disease Management Programs**: Asthma cannot be cured, but most people with asthma can control their symptoms and prevent asthma attacks by avoiding asthma triggers and correctly using prescribed medicine such as inhaled corticosteroids. COPD is a group of lung diseases that cause you to have trouble breathing. Our programs will help you stay healthy by stopping acute episodes before they happen and keeping you out of the emergency room.
- **Connections Plus® Cell Phone**: MHS can lend a cell phone to our members enrolled in care management who do not have access to a regular phone. Connections Plus cell phones are programmed to make calls to and receive calls from the MHS Care Management team, a member's PMP, other doctors in the treatment plan, MHS' 24 hour nurse advice line and family who support the member's care plan.

Earn Rewards!

My Health Pays® Rewards for Disease Management Coaching	
Initial intake assessment	$10
Creation of care plan with measurable goals	$25
Successful closure of care plan	$50
TOTAL POSSIBLE REWARDS	**$85**

Pregnancy & First Year of Life Programs

Start Smart for Your Baby® and MHS Special Deliveries (Exclusively offered to MHS Members)

At MHS, your health and your baby's well-being are our top priorities. We're here to support you every step of the way with personalized programs designed just for you. We have two programs for MHS members who are pregnant called Start Smart for Your Baby® and MHS Special Deliveries. By joining either program, you will be eligible to earn more My Health Pays® rewards. Learn more about My Health Pays® on page 42.

Start Smart for Your Baby® offers educational resources to guide you through every stage of your pregnancy, while MHS Special Deliveries provides personalized care management for those who may need extra support based on their medical history. MHS Care Managers will talk to you and suggest the program that is right for you based on your medical history and your doctor's plan of care.

Regardless of the program you choose, our dedicated MHS OB Nurses are here to ensure you receive the comprehensive care and resources you need during and after your pregnancy. MHS OB Nurses can:

- Help you understand what is happening to your body during the pregnancy
- Talk about problems that may come up during your pregnancy
- Talk about what to do if you have complications during your pregnancy
- Help you make doctor appointments or schedule a free ride to the doctor's office
- Help you get a free cell phone if you need one. You can use this phone to reach your doctor, family and other important people while you are pregnant.
- Help you quit smoking or using tobacco
- Help you find more ways to earn My Health Pays® rewards by going to your OB doctor visits
- Answer any other questions about your health and the health of your baby

We want to help you take care of yourself and your baby throughout your pregnancy. Information may be sent by mail, telephone and email and is available on our website, mhsindiana.com. A home visit with an OB nurse can also be arranged.

First Year of Life (Exclusively offered to MHS Members)

As you embark on the incredible journey of motherhood, our First Year of Life program is here to guide and support you. From answering your questions to providing helpful resources, our nursing staff is dedicated to helping you navigate the joys and challenges of your baby's first year. We will also call you and send reminders to schedule upcoming immunizations (shots) and well-child visits with your baby's doctor as they are needed.

Join our First Year of Life program today and let us be your partner in ensuring your baby's healthy development. We're here to make your first year of motherhood as smooth and joyful as possible.

Additional Programs

Free Birth Control Options (Family Planning)
YFamily planning services, including free birth control options, are designed to help you make informed choices about your reproductive health. This is a covered, self-referral program. That means you may go to any family planning clinic that accepts Healthy Indiana Plan. However, we encourage you to get your family planning services from your doctor or another MHS doctor. If you're unsure where to access these services or prefer not to discuss them with your doctor, contact MHS Member Services at 1-877-647-4848 for assistance. Your privacy is our priority.

Right Choices Program
The Right Choices Program helps ensure that members who need extra support in managing their health receive coordinated care from a dedicated healthcare team. Members may be referred to the Right Choices Program if they frequently use Medicaid services, to ensure they receive consistent and focused care from one doctor and one pharmacy. They must use these specific facilities for all healthcare needs, except for in an emergency.

Members referred to the program will receive a letter from MHS welcoming them to the program. The Right Choices enrollment period may last up to two years and may be renewed for an additional two-year period on review. However, members have the right to appeal their referral to the program within 60 days. For further questions, or if you have received a welcome letter, please call the MHS Right Choices Administrator at 1-877-647-4848.

Stop Smoking or Using Tobacco

Ready to breathe easier and live longer? MHS is here to help you quit smoking and break free from tobacco for good. Tobacco use remains the single most preventable cause of death and disease in the United States, claiming more than 480,000 lives per year. Quitting smoking can have immediate as well as long-term benefits for you and your loved ones. Let us help you today!

Call the FREE, CONFIDENTIAL Indiana Tobacco Quitline today at 1-800-QUIT-NOW (1-800-784-8669). The Quitline is an evidence-based telephone counseling program that offers one-on-one coaching to tobacco users who have decided to quit, provides professional support throughout your journey and discusses medication support. If you are not ready to quit, the Quitline staff will help you figure out what you can do to prepare yourself to successfully quit. Additionally, the Quitline offers a Web Coach and texting support – Text2Quit. **Plus you can earn My Health Pays® rewards for trying to quit. Check out the table on page 42 to see how much you can earn.**

1.800.QUIT.NOW
Indiana's Tobacco Quitline
QuitNowIndiana.com

Key Program Features include:

- Counseling offered in more than 170 languages
- 24/7 access to highly-trained and dedicated Quit Coaches
- One-on-One proactive telephone counseling with a Quit Coach
- Development of a quit plan to improve your chances of success including choosing a Quit Date
- Free 2-week Nicotine Replacement Therapy starter kit (gum/patches) for those that are eligible
- Expanded services for pregnant women, youth tobacco users (13-17 years old) and members with behavioral health diagnosis
- Practical advice and tips to help you cope with cravings, find ways to change your daily activities/behaviors that trigger smoking and avoid weight gain
- Enroll in the Web Coach only service to Set a Quit Date, Pick a Medication, Conquer and Control Your Urges, Control Your Environment and Get Social Support
- For additional support, enroll in the Text2Quit program to receive up to 300 text messages tailored to your quit plan

Reasons to Quit

- **Tobacco use is responsible for 1 out of every 5 deaths in the U.S.**
- **Smokers live 10 years less, on average, than non-smokers.**
- **Smokers have more health problems and visit the doctor much more than non-smokers.**
- **The average smoker in Indiana will spend more than $2,500 on cigarettes each year. That's $130,000 over a lifespan!**

There are many great reasons to quit. Ask MHS for help today.

HIP members who use tobacco have 12 months to stop tobacco use or you will have a higher POWER Account contribution (PAC). If you do not stop using tobacco your PAC payment will have a 50% surcharge applied. Please contact us today to learn about our programs that can help you quit.

Transportation

MHS HIP State plans and HIP Maternity plan members may receive transportation services to covered medical services, including doctor's appointments, dental care, behavioral health appointments, etc. as well as trips to the pharmacy for eligible members with no other means of transportation. HIP Plus and HIP Basic members may be eligible for transportation benefits if actively engaged in Case Management services. Speak to your case manager to learn more. You can reach MHS' transportation vendor through MHS Member Services at 1-877-647-4848. Select the prompt for "transportation". You can speak to a live transportation representative between 8 a.m. - 8 p.m. Monday through Friday. If you are calling after hours or have urgent transportation needs, a live agent can still help!

Please call to schedule your ride two (2) business days before your schedule medical visit. Schedule your doctor appointment before you call to get a ride. Members can schedule a ride forty-five (45) days before their appointment. The scheduling timeframe does not include weekends, holidays, or the actual appointment date. If you need to cancel or change your appointment, call us right away to cancel or change your ride.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			Dr. Smith check-up @10 a.m.		Call for a ride TODAY!	

Here is some other information you may need to know about transportation:

- You may have up to a one-hour wait time for your ride to pick you up before your scheduled visit.
- If you need transportation due to an urgent care need, be aware it could take longer to arrive since this is not a pre-scheduled pickup. Call immediately to set up your ride.
- All transportation for those who qualify must be for a medical appointment that is covered by Indiana Medicaid, as well as trips to the pharmacy for eligible members with no other means of transportation.
- If you have a life-threatening emergency, call 911 or your local emergency number.

You may take one other person along with you. Any additional riders must be approved in advance. Transportation will try to work with your situation if you request additional riders. Transportation may refuse to transport any persons who were not approved to ride in advance.

Please have the following information available when you call for a ride:

- You or your child's Medicaid card
- Your address and phone number
- The date and time of the appointment
- Name, address and phone number of the office or clinic
- Number of persons who will be riding (patient and parent or guardian only)
- Whether you will need a wheelchair-accessible van
- Whether you will need assistance to and from the door
- Members will need to provide their own car seats. Transportation will refuse to transport any child without the proper safety seat.

Calling for a pickup after your appointment:

- It may take from 15 minutes to one hour for a car to arrive after you call
- Transportation can take you to a pharmacy on the way home from a doctor visit
- Please be ready when your ride arrives
- Transportation will pick you up at the same place they dropped you off. They cannot pick up multiple family members at different locations.

Programs Just For MHS Members

These programs are designed to improve the health of our members through education and personal assistance by our professional staff. Call us today to ask about how to get these services we designed just for you.

myhealthpays®

MHS rewards members' healthy choices through our My Health Pays® program. Members can earn dollar rewards for things like screenings, preventive care and more. Use your My Health Pays® rewards to help pay for **everyday items at Walmart***, **utilities**, **transportation**, **telecommunications** (cell phone bill), **childcare services, education** or **rent**.

Get started today! You can start earning My Health Pays® rewards as soon as you become an MHS member. Complete any of the eligible healthy activities outlined below. Then reward dollars are automatically put on your My Health Pays® card. All new members are mailed a My Health Pays® card.

Earn rewards by completing the following healthy activities:

$30	Complete a health needs screening within 30 days of becoming a member.
$10	Complete a health needs screening within 90 days of becoming a member.
$10	Per infant well care visit up to 15 months old ($60 max). (These visits are recommended before 30 days old and at 2, 4, 6, 9, 12 and 15 months old)
$20	Annual well care visit with a primary care doctor. (One per calendar year; age 16 months and up)
$20	For an annual dental visit. (ages 1-20 only; one per calendar year)
$100	For completing the Indiana Tobacco Quitline Program.
$50 if within 1st trimester $25 if within 2nd trimester	Submit a Notification of Pregnancy (NOP) form to MHS. Login to your member portal account to complete your NOP.
up to $80	Participation in OB Case Management: Visit mhsindiana.com/rewards for details.
$20	Postpartum visit: See your doctor 3-8 weeks post delivery.

To check your balance, log into your secure portal account or call 1-866-809-1091.

*This card may not be used to buy alcohol, tobacco, or firearms products. This card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A Inc. The Bancorp Bank; Member FDIC. Card cannot be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage restrictions. Funds expire 90 days after termination of insurance coverage or 365 days after date reward was earned, whichever comes first.

Did you know you can use My Health Pays® Rewards to pay your monthly payment?

Live Great Program
In support of addressing another basic need, access to healthy foods, MHS provides financial rewards of up to $20/month for six months for the purchase of and direct access to healthy foods for members with chronic conditions. Through our Live Great program, MHS provides additional funds on a member's My Health Rewards card that can be used at Walmart for the purchase of foods designated by Walmart as "Great For You" for members experiencing food insecurities or a high-risk condition, such as diabetes. In addition, we arrange medically tailored (shelf stable) food packages for members with diabetes or heart disease experiencing food insecurity.

Post Discharge Meals
Members recuperating from an inpatient admission may not be ready to cook for themselves. In addition, diabetes and coronary artery disease are often linked to diet. We aim to acquaint/reacquaint members with foods appropriate to a heart or diabetic health diet by providing members discharged from the hospital with a diagnosis of diabetes or coronary artery disease with ten (10) healthy, home-delivered meals at the time of discharge planning following an acute inpatient hospital stay or discharge from a nursing facility back into the community setting.

Person-Centered Care Grants
Care grants are an extremely valuable and beneficial opportunity for our Care Coordination staff to ensure members have access to those additional products and programs that will support their personal needs. Our person-centered care grants replace the concept of a list of items provided to members as extra benefits, such as gym memberships and Weight Watchers program fees that may only appeal to a low percentage of the membership. Instead, our Care Coordination staff are allocated a person-centered care grant budget by which they can match members with the unique benefits that will contribute to their individual health and wellness. For example, walking shoes, water aerobics, community classes, hypoallergenic bedding, or a gas card.

Member Advisory Council
MHS invites groups of our members from around the state to talk with us four times a year. Discussions include the services MHS provides and how members feel about their doctors as well as how they feel about our programs. Members also look at our print materials and website information. MHS uses this information to make program changes based on our members' feedback. If you are interested in being part of our Member Advisory Council, call MHS Member Services at 1-877-647-4848.

Family Education Network
MHS and the Indiana Minority Health Coalition have teamed up to create the Family Education Network. The network provides face-to-face and phone benefit education to MHS members on a variety of topics. The network representatives can help explain Medicaid health plan benefits and coverage as well as an overview of MHS programs and special services available to you. Call MHS Member Services to schedule a free referral at 1-877-647-4848.

Plan Changes and Redetermination

MHS is your health coverage plan. You either chose MHS or were assigned to MHS to provide your health coverage when you joined HIP.

HIP now matches your health plan choice to the calendar year. You will pick your health plan once per year and stick with that health plan all year, January through December. This is your benefit year. Even if you leave the program and return during the year, you will stay with the same health plan.

This does not change your eligibility period for the program. You still have to go through your redetermination process every 12 months. This means you need to renew your benefits by confirming information with the state to show you are still eligible for HIP. This will occur based on what month you entered the program. You will get a reminder that it is time for your eligibility redetermination. If you do not respond as directed, you could lose coverage.

Benefit Year: January – December. Your benefit limits and POWER Account reset each January.

Eligibility Period: 12 months that starts when you are approved for coverage. This can be different for each person.

Native American and Alaska Natives
Native Americans/Alaska Natives have the option to opt out of managed care and receive fee-for-service coverage. If you are a Native American/Alaska Native and wish to opt out of managed care, please contact your enrollment broker.

HIP Disenrollment Request

Members will have the opportunity to change their managed care entity (MCE) at the following times:

- Within ninety (90) days of starting coverage before either (i) making your initial POWER account contribution or fast track prepayment or (ii) being enrolled in HIP Basic or HIP State Plan Basic in accordance with Section 13.6, whichever occurs first;
- Once per calendar year for any reason during the open enrollment period, from November 1 to December 15th effective the next calendar year;
- During the Medicare open enrollment window (mid-October-mid December) to be effective the following calendar year.
- At any time using the "for cause" process (defined below)

For Cause Health Insurance Plan Changes

Any Medicaid member may change their managed care entity (MCE) "For Cause". Determination as to whether a member has met one of these reasons is solely the determination of the Enrollment Broker and FSSA. The reasons include, but not limited to, the following:

- Receiving poor quality of care;
- Failure to provide covered services;
- Failure of the Contractor to comply with established standards of medical care administration;
- Lack of access to providers experienced in dealing with the member's health care needs;
- Significant language or cultural barriers;
- Corrective action or intermediate sanctions levied against the Contractor by the office per 42 CFR 438.56(c)(2)(iv);
- Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;
- A determination that another MCE's formulary is more consistent with a new member's existing health care needs;
- Lack of access to medically necessary services covered under the Contractor's contract with the State;
- A service is not covered by the Contractor for moral or religious objections
- Related services are required to be performed at the same time and not all related services are available within the Contractor's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;
- The member's primary healthcare provider disenrolls from the member's current MCE and reenrolls with another MCE;
- A member that was not given the opportunity to select an MCE in open enrollment may change their MCE during the first 60 days of the new benefit period;
- A change in aid category;
- Other circumstances determined by the State or its designee to constitute poor quality of health care coverage;

To request a for cause change, please call the Healthy Indiana Plan Enrollment Broker at 877-438-4479. They will answer your questions and provide you a form to request a health plan change, if needed. Before submitting a "for cause" request, you must contact MHS so that we can help resolve your concern through the grievance and appeals process. If we are unable to resolve your concern after going through the MHS grievance and appeals process, you may submit a request to change your health plan to the Enrollment Broker by phone or in writing.

If you want to leave MHS or your doctor because you are unhappy with MHS, please call MHS Member Services at 1-877-647-4848. We may be able to help you. Or please see page 47 for more information about complaints.

Redetermination

At the end of your eligibility year, you will need to confirm information with the state to show that you are still eligible for HIP. Contact the Division of Family Resources or visit FSSABenefits.IN.gov to find out what is required for you to continue your benefits.

You must participate in your annual eligibility redetermination process. Letters for your eligibility come from the Department of Family Resources (DFR). You must follow the directions provided by DFR. It can take about 45 days to re-apply or confirm your information with the state. To help you, MHS will call you and send you an email to remind you when you are 45 days from your last day of eligibility.

Medicare Eligibility
Are You Turning 65 Soon? If you are, the date you enroll in Medicare is important and can impact the date your coverage begins and the amount you pay each month. It's important to sign up as soon as possible to avoid penalties or gaps in coverage. There are 3 enrollment periods for Medicare:
- The three months before your 65th birthday, then Medicare becomes effective on the first day of the month you turn 65.
- The month of your 65th birthday, then Medicare becomes effective on the 1st day of the month after your birth month.
- The three months after your 65th birthday, it will take up to 60 days for your Medicare coverage to start.

If you miss the enrollment periods you must wait for a General Enrollment period. The General Enrollment period is January 1 through March 31 of each year. Your Medicare coverage will begin July 1 of that year. You will pay a Part B Late Penalty: 10% surcharge for each year you are late in enrolling. This penalty continues forever. For example, if you enrolled four years late, then you will pay a 40% surcharge for every year that you buy Part B.

To apply for Medicare, contact the Social Security Administration at (800)772-1213 or http://www.ssa.gov.

Quality Improvement Program

MHS wants to help you get the quality care you deserve. The MHS Quality Improvement (QI) program reviews all care and services you get from MHS doctors, hospitals and other services you receive. This helps ensure the care you receive is of good quality, helpful and right for you. If you want to get more information about MHS' QI program, call us or visit mhsindiana.com where you can find:
- The MHS QI summary and program description
- Immunization information for adults and children
- Standards MHS seeks to meet and exceed
- Medical record standards and practice guidelines

Member Satisfaction Surveys
As part of the Quality Improvement program, every year some members are asked to answer a survey to tell us about the care and services they receive from MHS and MHS doctors. MHS shares the survey answers with MHS doctors and uses the information to help improve member care and how we communicate with you. Your answers to these surveys are always anonymous, meaning we do not know who answered the survey. If you get a survey in the mail or over the phone, please take the time to answer and return the survey. It will help make MHS and the state healthcare programs the best they can be for you and your family.

Provider Qualifications
You have the right to see information about your doctor, specialist or other provider. You can find a provider's name, address, telephone number, professional qualifications, specialty and board certification status using our Find-A-Provider tool at mhsindiana.com. For information about a provider's medical school or residency, call Member Services. Our lists are updated any time there is a change. Or you can call us and ask for a list of providers to be mailed to you.

We hope our members will always be happy with MHS and our providers. Please let us know if you are not happy with any of the following:
- MHS programs and services.
- Services provided by your doctor.
- Decisions that MHS made as to your healthcare.

We will address any problems you might have.

Complaints

To make a complaint, call MHS Member Services at 1-877-647-4848. MHS takes your complaints seriously. We record your complaint and follow up with you about how we can serve you better. MHS will respond to your complaint with an outcome within one (1) business day. If you are unhappy with how your complaint is handled or if it took more than one (1) business day, your complaint will turn into a grievance.

Grievances

You or your authorized representative can file a grievance about your concern at any time. Grievances can be filed with MHS in the following ways:
- Writing: MHS Appeals, P.O. Box 441567, Indianapolis, IN 46244
- Orally: MHS Member Services, 1-877-647-4848
- In Person: 429 N Pennsylvania St., Suite 109, Indianapolis, IN 46204
- Online on the Secure Member Portal: www.mhsindiana.com/members.html

A written grievance needs to have:
- Your name, phone number, address and signature.
- Your member identification number.
- The reason(s) why you are unhappy.
- How MHS can help.

You can share copies of papers that help support your case in person or in writing.

MHS will send you a letter within three (3) business days to tell you we have your grievance on file. The letter includes your rights and next steps. All grievances are resolved within 30 calendar days. The resolution is sent to you in the mail within 30 calendar days. MHS may ask for an extra 14 calendar days to make a decision. If we need more time, we will let you know in writing before the 30-calendar day deadline. You may ask for an expedited grievance if you believe a standard grievance could seriously risk your life or prevent your ability to regain the most function. You can file a grievance if you disagree with the new timeline.

If you are not happy with the resolution, you have the right to appeal.

Appeals

An appeal is when you, your provider or your representative are not happy with the result of a decision made by MHS and wish to take action. This may be because you are not happy with the results of a grievance you filed. Or it might be because you are not happy with a decision MHS made when your doctor asked for prior authorization or

prior approval for some treatment, therapy, medical tools or other medical service. To name a representative or your provider, send MHS a signed letter or consent form telling us who will be your representative.
Appeals need to be filed within 60 calendar days from the date on the letter telling you about the decision. You or your representative may file an appeal request and consent (if a representative) by:
- Mail: MHS Appeals, P.O. Box 441567, Indianapolis, IN 46244
- Phone: MHS Member Services or MHS Appeals at 1-877-647-4848
- Fax: 1-866-714-7993
- Email: appeals@mhsindiana.com

Your written appeal should have:
- Your name, phone number, address and signature.
- Your member ID number.
- The reason(s) why you are unhappy.
- How MHS can help.

You can share copies of papers that support your case in person or in writing.

MHS will write to you within three business days to say we have your request. Your case will go to a person with the right knowledge to review your case, such as a physician or administrative manager. The person assigned will not have been involved in prior decisions.

All appeals are resolved within 30 calendar days. The result is mailed to you within 30 calendar days. MHS may ask for an extra 14 calendar days to make a decision. If we need more time, we will let you know by mail before the 30-calendar day deadline. If you are not happy with the appeal result, you may have the right to an outside, separate review.

Expedited Appeal:
MHS may extend the time for processing an expedited appeal up to fourteen (14) calendar days if you ask for the extension or if MHS needs more information. If the time is extended and you did not ask for the extension, MHS will tell you within two (2) calendar days by phone and in writing with the reason for the delay. The written notice will include the reason for the decision. If you disagree with the extension, you have the right to file a grievance.

External Independent Review and State Fair Hearing (EIR)**

External Independent Review
If you are not happy after the appeal decision, you may ask for an External Independent Review (EIR) by an Independent Review Organization (IRO). An EIR is sent to an IRO to review our appeal decision. An IRO will review a decision based on medical necessity, experimental or investigational.

To ask for an EIR by an IRO, call or write to us within one hundred twenty (120) calendar days from the date on the appeal decision letter. We will send the complete case file to an IRO at the Indiana Department of Insurance. Medical staff will review the case. They will send their answer to you in fifteen (15) business days. MHS will pay for this review.

State Fair Hearing

After an appeal, if you do not agree with the decision, you may ask for a State Fair Hearing (SFH) with the Indiana Family and Social Services Administration (FSSA) within one hundred twenty (120) calendar days from the date on your appeal decision letter. You may ask for a State Fair Hearing at the same time as your external independent review request. You must exhaust the MHS grievance and appeals process before you can a State Fair Hearing. You may call MHS to set up the hearing or write to the FSSA directly at:

Office of Administrative Law Proceedings
100 N. Senate Avenue, Room N802
Indianapolis, IN 46204
Fax: 317-232-4412
Email: fssa.appeals@oaip.in.gov

After your hearing request is received at FSSA, a judge will hear your case and write to you with a decision within 90 days of receiving your request. If you disagree with the decision, you can ask for an agency review. You may request an agency review within ten (10) business days from your notice. You will receive a formal notice of the agency's decision. If the hearing decision changes, the reason will be included. You can ask for a judicial review of the agency's decision if you disagree.

Care During Appeals

You are still our member during an appeal. You will continue to get all covered healthcare services for your benefit package. MHS will cover the care you are appealing until the final decision is made. If the final decision on your appeal is to deny the services, you may have to pay for those covered services.

To maintain benefits during your appeal:

a. You or the provider must file the appeal within ten (10) days of MHS mailing the notice, or the intended effective date; whichever is later.
b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
c. The services were ordered by an authorized provider.
d. The term covered by the original authorization has not expired.
e. You request an extension of benefits.

Your Appeal Rights and Choices

If MHS makes a decision about your care and you disagree, as an MHS member, you have a right to ask us to review the decision:

- You may write or call MHS to file an appeal and ask us to review the decision. You must contact us within 60 calendar days from the date MHS made its decision. If you miss that deadline, you will not be able to have the case reviewed.
- You may ask MHS to help you. If you call us, MHS will help you by filling out a member appeal.
- You may send MHS medical documentation, statements or other evidence, or any allegations of fact or conclusions of law you think we should know. You may ask your treating physician or your primary care doctor to send us information you think we should have.
- You may ask someone to represent you, like your doctor or a lawyer, a family member or another person you trust. To name a representative, send MHS a signed letter or note telling us the name of the person, your relationship with the person, and how to call or write to them. You don't have to name a representative if you don't want to.
- If you believe waiting the regular time for the answer to your appeal will harm your life or health, you may ask MHS to consider doing an extra-fast review of your case, called an "expedited review." You must ask for this as soon as possible by calling or writing to MHS.
- You may participate in resolving your case by contributing paperwork you would like reviewed and by meeting with the panel reviewing your case, either in person or on the phone. You must let us know your plan to participate in advance when you call or write to us. You may have the person you named to represent you join you in participating in the resolution of your case.
- You may review any medical records MHS has on file for you, and you may review your case file both before and during the appeal process, free of charge. To ask to see the information, please call or write to MHS.
- You may contact MHS Member Services to check on the status of your case by phone at 1-877-647-4848 or online at mhsindiana.com/contact-us.
- If you are not satisfied with the results of the MHS review of your case, you have the right to go to the next level of appeal including Independent Review, State Fair Hearing, or both.

Member Ombudsman

The MHS member ombudsman program is a partnership between MHS and Mental Health America of Indiana. An ombudsman is someone who works to help you get a problem solved. MHS members can contact an ombudsman for free to discuss any problems they may be having with MHS, MHS services, MHS doctors or any other part of their healthcare. The ombudsman is neutral, so they do not side with MHS or the Medicaid program. The ombudsman will work with you to get your problem solved. If you are an MHS member (or a legal representative), please call if:

- You have questions about your MHS benefits or services.
- You want to know what your MHS rights and responsibilities are for your MHS coverage.
- You need help with the appeals process, including filling out the proper paperwork, documenting verbal appeals or guidance through the appeals process.

If you want the assistance of an ombudsman, please call them toll-free at 1-877-647-5326, 8 a.m. - 8 p.m. Monday through Friday.

Medical Decisions

MHS providers and staff make decisions about treatments for our members based on providing the best care and service possible. MHS does not reward any provider, doctor or member of their staff for denying or reducing services or payment. MHS does not reward or pay doctors or MHS staff to keep you from getting less care than you need.

MHS does not make coverage decisions based on moral or religious beliefs. You may have a request that a certain doctor or hospital cannot follow because of their moral or religious beliefs. If that happens, that doctor or hospital should tell you so you can decide if you want a different doctor or hospital to care for you. If you have an advance directive and your doctor does not follow your wishes, you can file a complaint with the Indiana State Survey and Certification Agency.

Doctor Incentives
MHS provides incentives for doctors based on the quality of healthcare provided to our members. For example, pediatricians are encouraged to make sure children get immunizations (shots). We do not give incentives to MHS doctors for not providing care. For more detailed information about MHS' incentive plans for doctors, please call MHS Quality Improvement at 1-877-647-4848.

Advance Directives
Advance directives refer to your spoken and written instructions about your future medical care and treatment. By stating your health care choices in an advance directive, you help your family and physician understand your wishes about your medical care. Indiana law pays special attention to advance directives. Advance directives are normally one or more documents that list your health care choices for when you cannot make the choices for yourself. With advance directives, you can:

- Let your doctor know if you would or would not like to use life-support machines
- Let your doctor know if you would like to be an organ donor
- Give someone else permission to say "yes" or "no" to your medical treatments

Advance directives are only used if you can't speak for yourself. It does not take away your right to make a different choice if you later become able to speak for yourself. There are many ways to make advance directives:

- Talk to your doctor and family
- Choose someone to speak or decide for you, known as a health care representative
- Power of Attorney and/or Living Will

For more information about your rights under Indiana law you can visit the Indiana State Department of Health website at
https://www.in.gov/isdh/25880.htm.

New Treatments and Technologies
MHS has a group of physicians and staff who regularly look at new services, treatments and drugs that become available to help make sure you get good care.

Notice about MHS as a Second Payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

MHS has the right and the responsibility to collect payment for covered services when someone else has to pay first.

MHS' Right of Subrogation
Subrogation is the process by which MHS gets back some or all of the costs of your healthcare from another insurer or responsible party. Examples include:

- Your motor vehicle or homeowner's insurance
- The motor vehicle or homeowner's insurance of an individual who caused your illness or injury
- Workers' compensation

If an insurer other than MHS should pay for services related to an illness or injury, MHS has the right to ask that insurer to repay us. MHS is subrogated to any right of recovery you have against a third person who caused your illness or injury, or any right of recovery you have against another insurance plan, including but not limited to any uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, no-fault automobile insurance coverage or any other first party insurance coverage. Unless otherwise required by law, coverage under this policy by MHS will be secondary when another plan, including another insurance plan, provides you with coverage for healthcare services.

MHS' Right of Reimbursement
If you get money from a lawsuit or settlement for an illness or injury, MHS has a right to ask you to repay the cost of covered services that we paid for. We cannot make you repay us more than the amount of money you got from the lawsuit or settlement.

Your Responsibilities
As a member of MHS, you agree to:

- Let us know of any events that may affect MHS' rights of subrogation or reimbursement.
- Cooperate with MHS when we ask for information and assistance with coordination of benefits, subrogation, or reimbursement.
- Sign documents to help MHS with its rights to subrogation and reimbursement.
- Authorize MHS to investigate, request and release information, which is necessary to carry out coordination of benefits, subrogation, and reimbursement to the extent allowed by law.
- Pay all such amounts to MHS recovered by lawsuit, settlement or otherwise from any third person or his or her insurer, or from your insurer, including but not limited to any uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, no-fault automobile insurance coverage or any other first party insurance coverage to the extent of the benefits provided under the coverage, up to the value of the benefits provided.
- If you are not willing to help us, you may have to pay us back for our costs, including reasonable attorneys' fees, in enforcing our rights under this plan.

Waste, Fraud And Abuse Of The Program

Preventing and limiting waste, fraud and abuse helps protect the healthcare programs that serve you and your family. If you think a plan member or a provider has committed waste, abuse or fraud, you have a right and a responsibility to report this. Examples of member fraud or abuse include:

- A member who lets someone else use their member ID card to get medical care
- A member who seeks to have the plan pay for drugs he or she does not need

Examples of provider fraud or abuse include:

- A provider that orders unnecessary tests.
- A provider that orders DME that you do not need.

Your safety and well-being are very important to us. If you or your family has any concerns, please call us right away. If you think a provider, member or another person is misusing the program, tell us immediately. MHS is serious about finding and reporting waste, fraud and abuse. Call our confidential toll-free hotline at 1-866-685-8664. You may also call the Indiana Family and Social Services Administration confidential, toll-free hotline at 1-800-403-0864. You will not need to give your name.

MHS Member Rights & Responsibilities

- Receive information about MHS, as well as MHS services, practitioners, providers and your rights and responsibilities. We will send you a member handbook when you become eligible and a member newsletter four times a year. In addition, detailed information on MHS is located on our website at mhsindiana.com. Or you may also call MHS Member Services at 1-877-647-4848.
- Obtain information about the structure and operation of MHS
- Be treated with respect and with due consideration for your dignity and privacy
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand
- A candid discussion of appropriate or medically-necessary treatment options, regardless of cost or benefit coverage
- Participate with practitioners in decisions regarding your healthcare, including 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 regulations on the use of restraints and seclusion
- Request and receive a copy of your medical records, and request they be amended or corrected as allowed in federal healthcare privacy regulations
- Voice complaints, grievances or appeals about the organization or the care it provides
- Make recommendations about our Member Rights and Responsibilities policy
- An ongoing source of primary care appropriate to your needs and a person formally designated as primarily responsible for coordinating your healthcare services
- Personalized help from MHS staff so you can ensure you are getting the care needed, especially in cases where you or your child have "special healthcare needs" such as dealing with a long-term disease or severe medical condition. We make sure you get easy access to all the care needed and will help coordinate the care with multiple doctors and get case managers involved to make things easier for you. If you have been determined to have a special healthcare need by an assessment under 42 CFR 438.208(c)(2) that requires a course of treatment or regular care monitoring, we will work with you to provide direct access to a specialist as appropriate for your condition and needs.
- Have timely access to covered services
- Have services available 24 hours a day, seven days a week when such availability is medically necessary
- Get a second opinion from a qualified healthcare professional at no charge. If the second opinion is from an out-of-network provider, the cost will not be more than if the provider was in-network.
- Direct access to women's health specialists for routine and preventive care, including family planning, annual women's tests and OB service, without approval by MHS or your MHS doctor. This includes birth control, HPV tests, chlamydia tests and annual Pap smears.
- Receive written notice of a decision to deny a service authorization request or to authorize a service in an amount, duration or scope less than requested. You will receive this information as quickly as needed so your medical needs are met and treatment is not delayed. We will not jeopardize your medical condition waiting for approval of services. Authorizations are reviewed based on your medical needs and made in compliance with state timeframes.

As an MHS member, you have the responsibility to ...

- Provide information (to the extent possible) needed by MHS, its practitioners and other healthcare providers so they can properly care for you
- Follow plans and instructions for care which you have agreed to with your MHS doctors
- Understand your health problems and participate in developing mutually-agreed-upon treatment goals to the degree possible

Benefit	Health care service coverage that a Medicaid member receives for the treatment of illness, injury, or other conditions allowed by the State.
Case Management	MHS programs for members with special health conditions that help members manage their conditions by routine contact and help from MHS.
CAHPS®- Consumer Assessment of Health Care Providers System	An annual, random survey of members to measure satisfaction with the service and care provided by the Plan and the Plan's primary medical providers (PMPs) and specialists. CHINS-Children in Need of Services
Children's Health Insurance Program HHW Package C (CHIP)	A part of the Balanced Budget Act of 1997 that includes an expansion of the Medicaid program that extends coverage to children ages zero to 19 years old whose family income is the Federal Poverty Level (FPL). CHIP is also known as Hoosier Healthwise Package C.
CMS	Centers for Medicare and Medicaid Services, the federal agency that oversees health plans and health care delivery. CMS is part of the Department of Health and Human Services (HHS).
Copayment	Money paid to the provider at the time of service (or might be billed to the patient to pay at a later time). Service cannot be refused due to inability to pay copayments at the time of service.
Cost Sharing	The out-of-pocket amount that an individual pays for their health care. Indiana Medicaid cost sharing requirements include copayments and premiums (also called contributions for HIP).
Covered Service	Mandatory medical services required by CMS and optional medical services approved by the State that are paid for by Medicaid. Examples of covered services are prescription drug coverage and physician office visits.
DME	Durable Medical Equipment
Division of Family Resources (DFR)	A Division of the Family and Social Services Administration. The State agency that offers help with job training, public assistance, supplemental nutrition assistance, and other services. Members can call an enrollment broker at 800-889-9949.
Eligible Member	Person certified by the State as eligible for medical assistance.
EPSDT	Early and Periodic Screening, Diagnostic and Treatment Services. These are a series of tests your child needs to receive from birth to age 21 to help them to keep from getting sick or to detect potential health problems early so they can be treated.
Explanation of Benefits (EOB)	An explanation of services rendered by your provider and any payments made toward those expenses.
Family and Social Services Administration (FSSA)	An umbrella agency responsible for administering most Indiana public assistance programs; includes the Office of Medicaid Policy and Planning, the Division of Aging, the Division of Family Resources, Office of Early Childhood and Out-of-School Learning, Indiana 211, the Division of Mental Health and Addiction, and the Division of Disability & Rehabilitative Services.
Health Needs Screening (HNS)	A questionnaire members are encouraged to complete within 90 days of MHS membership so MHS is aware of the individual's healthcare conditions. This allows MHS to match members' needs with the right programs and services.
HIPAA	Health Insurance Portability and Accountability Act. Loosely used to refer to PHI. HIPAA is designed to streamline health care delivery by employing standardized, electronic transmission of administrative and financial transactions, along with protection of confidential Protected Health Information (PHI).

Hoosier Care Connect (HCC)	Hoosier Care Connect is a health care program for individuals who are aged 65 years and older, blind, or disabled and who are also not eligible for Medicare.
Hoosier Healthwise (HHW)	Indiana's Medicaid health care program for children up to age 19 and pregnant women.
Healthy Indiana Plan (HIP)	The Healthy Indiana Plan is an affordable health insurance program from the state of Indiana for uninsured adult Hoosiers age 19-64.
Indiana Health Coverage Programs (IHCP)	Indiana Medicaid is a part of the Indiana Health Coverage Programs (IHCP), a number of programs that provide coverage for Hoosiers who are older adults, disabled, blind, pregnant, or otherwise eligible for coverage. This includes the Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise and Traditional Medicaid within Indiana..
Income	In terms of eligibility, money that you earn through a job, self-employment (earned income), or money that is paid to you directly, such as SSI or SSDI (unearned income).
WelTrans	The company MHS uses to provide transportation to eligible members.
MHS	Managed Health Services, abbreviated MHS
Medicaid	A program that offers health insurance to certain low-income families, individuals with disabilities, and elderly individuals with limited financial resources. Medicaid is jointly funded by the federal and state government.
Medically Frail	Individuals who are determined to be medically frail receive coverage for some additional benefits including non-emergency transportation and chiropractic services. You must contact the State in order to confirm your health condition. An individual is medically frail if he or she has 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.
Medically Necessary	Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
Member	A person who has chosen MHS as their health coverage plan and gets their benefits through MHS.
MHS Nurse Advice Line	MHS Nurse Advice Line is MHS' medical advice phone line staffed by registered nurses. MHS Nurse Advice Line is open 24 hours a day, every day of the year. Members can call 1-877-647-4848.
OTC	Over-The-Counter; refers to medications such as cold medicine and aspirin that can be purchased without a prescription.
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.
PHI	Protected Health Information. This is information about you and your health that must be maintained securely and is subject to laws that detail who can see the information and under what circumstances.

PMP	Primary Medical Provider, your MHS doctor. A pediatrician, general practitioner, family practitioner, internist or sometimes an obstetrician/gynecologist who has contracted with MHS to provide primary care to members and to refer, authorize, supervise and coordinate the provision of benefits. Nurse practitioners and physician's assistants associated with a contracted primary medical provider may see members seeking primary care.
POWER Account	In the HIP program, the first $2,500 of medical expenses for covered services are paid through a special savings account called a Personal Wellness and Responsibility (POWER) account. The state will pay most of this amount, but you will also be responsible for paying a small portion of your initial health care costs. Your portion is paid through an affordable, monthly contribution to your POWER account based on income.
Prior Authorization (PA)	A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary.
Provider	Any medical, dental or behavioral health professional who may provide care for our members. Most often it refers to physicians (doctors).
Recipient Identification Number (RID)/Member Identification Number (MID)	The unique number assigned to a member who is eligible for Medicaid services. This number can be found on the front of your Medicaid ID card.
Rollover	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.
Self-Referral	A covered service a member can get without having the approval of their MHS doctor, MHS or anyone else. A member may self-refer for special services that do not require pre-service review by MHS or the Primary Medical Provider (PMP).
Premiums and POWER Account Contributions	Monthly payments invoiced and paid monthly to your MCE. Ongoing coverage might be impacted if monthly premiums are not paid. There is a 60-day grace period for premium payment--as long as payment is made within 60 days of the due date, coverage will continue.
5% Out-of-Pocket Maximum	Individual cost sharing obligations are capped at 5% of family income as calculated on a quarterly basis. Once 5% cost sharing is met, the MHS will turn off cost sharing for the remainder of the quarter and resume at the beginning of the next quarter. For HIP Plus categories, if the 5% cost share limit is met, your PAC will be reduced to $1 for the remainder of the quarter

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective 5/2/2024

For help to translate or understand this, please call 1-877-647-4848 (TTY 1-800-743-3333).

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono.
1-877-647-4848 (TTY 1-800-743-3333).

Covered Entity's Duties
Managed Health Services (MHS) is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). MHS is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

MHS reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. MHS will promptly revise and distribute this Notice whenever there is a material change to the following:
- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice

We will make any revised Notices available on our website or through a separate mailing.

Internal Protections of Oral, Written, and Electronic PHI
MHS protects your PHI. We are also committed in keeping your race, ethnicity, and language (REL), and sexual orientation and gender identity (SOGI) information confidential. We have privacy and security processes to help. These are some of the ways we protect your PHI:
- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI
The following is a list of how we may use or disclose your PHI without your permission or authorization:

Treatment — We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.

Payment — We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, and reviewing services for medical necessity.

Healthcare Operations — We may use and disclose your PHI to perform our healthcare operations. These activities may include providing customer service, responding to complaints and appeals, and providing care management and care coordination.

In our healthcare operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes the following:
- Quality assessment and improvement activities
- Reviewing the competence or qualifications of healthcare professionals
- Case management and care coordination
- Detecting or preventing healthcare fraud and abuse

Your race, ethnicity, language, sexual orientation, and gender identity are protected by the health plan's systems and laws. This means information you provide is private and secure. We can only share this information with health care providers. It will not be shared with others without your permission or authorization. We use this information to help improve the quality of your care and services.

This information helps us to:
- Better understand your healthcare needs.
- Know your language preference when seeing healthcare providers.
- Providing healthcare information to meet your care needs.
- Offer programs to help you be your healthiest.

This information is not used for underwriting purposes or to make decisions about whether you are able to receive coverage or services.

Group Health Plan/Plan Sponsor Disclosures — We may disclose your PHI to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI

Fundraising Activities — We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

Underwriting Purposes — We may use or disclose your PHI for underwriting purposes, such as to decide about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.

Appointment Reminders/Treatment Alternatives — We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.

As Required by Law — If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.

Public Health Activities — We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness products or services under the jurisdiction of the FDA.

Victims of Abuse and Neglect — We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect, or domestic violence.

Judicial and Administrative Proceedings — We may disclose your PHI in response to an administrative or court order. We may also be required to disclose your PHI to respond to a subpoena, discovery request, or other similar requests.

Law Enforcement — We may disclose your relevant PHI to law enforcement when required to do so for the purposes of responding to a crime.

Coroners, Medical Examiners, and Funeral Directors — We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.

Organ, Eye, and Tissue Donation – We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of cadaveric organs, eyes, and tissues.

Threats to Health and Safety — We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

Specialized Government Functions — If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI to authorized federal officials for national security concerns, intelligence activities, the U.S. Department of State for medical suitability determinations, the protection of the President, and other authorized persons as may be required by law.

Workers' Compensation — We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Emergency Situations – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interest. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.

Inmates — If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.

Research — Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization
We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:
Sale of PHI — We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing — We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes — We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment, or healthcare operation functions.

You have the right to revoke your authorization, in writing at any time except to the extent that we have already used or disclosed your PHI based on that initial authorization.

Individuals Rights
The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

Right to Request Restrictions — You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment, or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

Right to Request Confidential Communications — You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where you PHI should be delivered.

Right to Access and Receive a Copy of your PHI — You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed. We will also tell you how to ask for such a review or if the denial cannot be reviewed.

Right to Amend your PHI — You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision, and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Receive an Accounting of Disclosures — You have the right to receive a list of instances within the last six-year period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.

Right to File a Complaint — If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019 (TTY: 1-800-537-7697) or visiting hhs.gov/ocr/privacy/hipaa/complaints/.

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

Right to Receive a Copy of this Notice — You may request a copy of our Notice at any time by using the contact information listed at the end of the Notice. If you receive this Notice on our website or by electronic mail (email), you are also entitled to request a paper copy of the Notice.

Contact Information

Questions about this Notice: If you have any questions about this notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone by using the contact information listed below.

MHS
Attn: Privacy Official
429 N Pennsylvania St., Suite 109
Indianapolis, IN 46204
1-877-647-4848
(TTY: 1-800-743-3333)

Statement of Non-Discrimination
Managed Health Services (MHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MHS:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - -Qualified sign language interpreters
  - -Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - -Qualified interpreters
  - -Information written in other languages

If you need these services, contact MHS at 1-877-647-4848 (TTY/TDD 1-800-743-3333).

If you believe that MHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Grievance and Appeals Coordinator, PO Box 441567, Indianapolis, IN 46244, 1-877-647-4848 (TTY/TDD 1-800-743-3333), Fax 1-866-714-7993. You can file a grievance in person or by mail, fax or email.

If you need help filing a grievance, MHS is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de MHS, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-647-4848 (TTY/TDD 1-800-743-3333).
Chinese:	如果您，或是您正在協助的對象，有關於 MHS 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-877-647-4848 (TTY/TDD 1-800-743-3333)。
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu MHS hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-647-4848 (TTY/TDD 1-800-743-3333) an.
Pennsylvania Dutch:	Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich MHS, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kawl 1-877-647-4848 (TTY/TDD 1-800-743-3333).
Burmese:	သင် သို့မဟုတ် သင်မှကူညီနေသူတစ်ဦးဦးတွင် MHS အကြောင်း မေးစရာများရှိပါက အခမဲ့အကူအညီ ရယူပိုင်ခွင့်နှင့် သင်၏ဘာသာစကားဖြင့် အချက်အလက်များကို အခမဲ့ရယူပိုင်ခွင့် ရှိပါသည်။ စကားပြန်တစ်ဦးနှင့် စကားပြောဆိုရန် 1-877-647-4848 (TTY/TDD 1-800-743-3333) ကို ဖုန်းဆက်ပါ။
Haitian Creole	Si ou menm, oswa yon moun w ap ede, gen kesyon sou MHS, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou kapab pale ak yon entèprèt, rele nan: 1-877-647-4848 (TTY: 1-800-743-3333).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول MHS، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أي تكلفة. للتحدث مع مترجم اتصل بـ 1-877-647-4848 (TTY/TDD 1-800-743-3333)
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 MHS 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-647-4848(TTY/TDD 1-800-743-3333)로 전화하십시오.
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về MHS, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-647-4848 (TTY/TDD 1-800-743-3333).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'MHS, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-647-4848 (TTY/TDD 1-800-743-3333).
Japanese:	MHS について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-647-4848 (TTY/TDD 1-800-743-3333) までお電話ください。
Dutch:	Als u of iemand die u helpt vragen heeft over MHS, hebt u recht op gratis hulp en informatie in uw taal. Bel 1-877-647-4848 (TTY/TDD (teksttelefoon) 1-800-743-3333) om met een tolk te spreken.
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa MHS, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-647-4848 (TTY/TDD 1-800-743-3333).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования MHS вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-647-4848 (TTY/TDD 1-800-743-3333).
Punjabi:	ਜੇ ਤੁਹਾਡੇ, ਜਾਂ ਤੁਹਾਡੀ ਮਦਦ ਲੈ ਰਹੇ ਕਸਿ ਵਿਅਕਤੀ ਦੇ ਮਨ ਵਿੱਚ MHS ਦੇ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫਤ ਮਦਦ ਲੈਣ ਦਾ ਪੂਰਾ ਹੱਕ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ 1-877-647-4848 (TTY/TDD 1-800-743-3333) 'ਤੇ ਕਾਲ ਕਰੋ।
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, MHS के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी परापत करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-877-647-4848 (TTY/TDD 1-800-743-3333) पर कॉल करें।

Get Insured. Get Healthy. Get Rewarded.

Get more with MHS.

Start earning rewards today!
Earn My Health Pays® Rewards to pay your monthly POWER Account Contribution!
Complete your Health Needs Screening to get $30 added to your
My Health Pays® Rewards card.

La versión en español de este libro estádisponible llamando al 1-877-647-4848.
Visit us online at mhsindiana.com.