Chase Center/Circle
111 Monument Circle
Suite 601
Indianapolis, IN 46204-5128
USA

Tel +1 317 639 1000
Fax +1 317 639 1001

milliman.com

January 27, 2011

Ms. Pat Casanova
Medicaid Director
State of Indiana
Family and Social Services Administration
402 W. Washington Street
Indianapolis, IN 46204

RE: BENCHMARK BENEFIT ANALYSIS OF THE HEALTHY INDIANA PLAN WITH ENHANCED BENEFITS

Dear Pat:

Milliman, Inc. (Milliman) has been retained by the State of Indiana, Family and Social Services Administration to provide consulting services related to benchmark benefit analysis of the Healthy Indiana Plan (HIP). Milliman provided an initial benchmark benefit analysis of the current plan in an August 16, 2010 correspondence. At that time, Milliman determined that the plan did not meet requirements for benchmark equivalent coverage as updated by the Patient Protection and Affordable Care Act (ACA). This correspondence provides an actuarial certification to the actuarial equivalency of the enhanced plan proposed in the State Plan Amendment to a benchmark benefit plan.

LIMITATIONS

The information contained in this correspondence, including any enclosures, has been prepared for the State of Indiana, Family and Social Services Administration, related Divisions, and their advisors. Milliman anticipates the results of this analysis will be shared with CMS. These results may not be distributed to any other party without the prior consent of Milliman. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling that will allow appropriate use of the data presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for FSSA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by FSSA and its vendors. The values presented in this correspondence are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented will need to be reviewed for consistency and revised to meet any revised data. The data and information included in the report has been developed to assist in analysis of the benefit package provided by the Healthy Indiana Plan (HIP). The data and information presented may not be appropriate for any other purpose.

SUMMARY OF RESULTS

Under health care reform legislation, Medicaid enrollees will need to receive a comprehensive medical benefits package known as Benchmark Equivalent coverage. To qualify, the benefits package must include certain mandatory benefits and also have an aggregate actuarial value at least as high as one of the benchmark plans. The benchmark plans include the Federal Employees Health Benefit Plan (FEHBP), Indiana State employee medical coverage, and the HMO plan with the largest insured commercial enrollment in the state.

Milliman has chosen to compare the actuarial value of HIP benefits to the value of those provided to Indiana State employees. The State of Indiana employee benefits program offers several health benefit options, the most valuable of which is a traditional PPO plan (under HIP utilization assumptions). Milliman compared the actuarial value of benefits to the actuarial value of the Traditional PPO plan offered to State Employees.

The HIP benchmark benefit analysis performed by Milliman in August 2010 indicated that current HIP benefits (those in place from January 2008 through the present time) do not meet benchmark equivalent coverage requirements as updated by ACA. Under ACA, the list of mandatory services that must be included in benchmark equivalent plans was substantially expanded to include pharmacy benefits, mental health parity, and a new list of "essential health benefits" that will also apply to subsidized plans on the Exchange. The benefit relativity of the current HIP base benefit package is 0.980 (less than 1.000). In addition, the current plan does not meet benchmark benefit requirements because it does not provide various essential benefits such as non-emergency transportation and maternity benefits.

Under the State Plan Amendment, the State has proposed enhancing HIP by adding the following benefits:

- **Maternity Benefits:** Under the current structure, HIP members who become pregnant are reenrolled in Medicaid Package B coverage. Under the proposed benefit enhancement, pregnant members would have full maternity benefits available under HIP and would have no need to change plans.

- **Non-Emergency Transportation Benefits:** Benefits provided would be the same as those available to Package A Medicaid enrollees in Indiana. Provider reimbursement would be at Medicare rates or 130% of Medicaid rates, consistent with reimbursement for other HIP services.

- **Vision Benefits:** Vision benefits would be provided to all HIP enrollees. Benefits provided would be the same as those available to Package A Medicaid enrollees in Indiana. Provider reimbursement would be at Medicare rates or 130% of Medicaid rates, consistent with reimbursement for other HIP services.

- **Dental Benefits:** Dental benefits would be provided to HIP enrollees under the age of 21 in order to meet EPSDT requirements. Benefits provided would be the same as those available to Package A Medicaid enrollees under the age of 21. Provider reimbursement was assumed to be at 130% of Medicaid rates, since Medicare does not provide dental coverage.

- **Annual Benefit Maximum and Lifetime Maximum:** Currently, HIP has an annual benefit maximum of $300,000 and a lifetime maximum of $1,000,000. These would be removed.

Table 1 illustrates the relativity of the benefits between plans using the benchmark plan as the 1.000 option. Values greater than 1.000 indicate that HIP is "richer" than the benchmark plan, and values less than 1.000 indicate that HIP is "leaner" than the benchmark plan and would not qualify as a benchmark benefit plan. Results illustrated in Table 1 indicate that HIP does not currently meet the benchmark benefit requirements, but would meet requirements after plan enhancements proposed in the State plan amendment.

Table 1
State of Indiana
Family and Social Services Administration
Benefit Relativity – Healthy Indiana Plan vs. State Employee Benchmark

HIP Benefit Relativity	Current Plan	Enhanced Plan
Base Medical Benefits	0.980	1.030
Vision Benefits	0.000	0.949

Vision benefits must have an actuarial value at least 75% of the benchmark plan.

Enclosure 1 contains 2010 current summary plan descriptions for the Healthy Indiana Plan as published by the two participating health plans: Anthem and MDWise. Enclosure 2 contains summary plan descriptions of health plans for State employees.

Under the benefits identified in the State Plan Amendment, the actuarial value of benefits under HIP is richer than under the benchmark plan.

ASSUMPTIONS AND METHODOLOGY

Milliman compared the actuarial value of benefits provided under HIP with coverage provided to State employees under the Traditional PPO option (State employees also have an option to select a CDHP). In addition, State employees have the option to purchase separate dental and vision coverage.

Benefit comparisons were performed using the Milliman Health Cost Guidelines. Benefits were valued under a standardized set of utilization, price factors, and population. For benefits not currently covered under HIP (e.g. maternity, non-emergency transportation), standard utilization assumptions for Indiana were used. HIP reimbursement, tied to Medicare reimbursement, was used as the pricing used to compare the plans.

In addition to comparing covered services, cost sharing was valued, taking into account deductibles, copays, coinsurance, and out of pocket maximums. Monthly premiums paid by State employees were not included in this analysis.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

If you have any questions or comments regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/lrb
Enclosures

Milliman

ENCLOSURE 1

Anthem®
Health. **Join In.**

HIP
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

Anthem Blue Cross and Blue Shield Healthy Indiana Plan℠

a health plan sponsored by the State of Indiana

WELCOME

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

Sí necesita asistencia en español, usted puede solicitarla sin costo adicional contactando a su corredor o agente de cuidados de la salud. También puede visitar www.anthem.com/espanol.

02/10

Welcome to the Healthy Indiana Plan, from Anthem Blue Cross and Blue Shield.

Anthem Blue Cross and Blue Shield's Healthy Indiana Plan℠ (HIP) is a new, affordable health care program for uninsured adult Hoosiers. The program offers health benefits, including physician services, mental health services, and prescription drug coverage. The program is subsidized by the State of Indiana, and therefore, requires only minimal monthly contributions from the participant.

It's all about your health. So let's start there first.

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

These services are fully covered when received from an in-network provider and the first $500 will not apply to your POWER Account. If any of these services are received for diagnostic purposes, for example, a colonoscopy when symptoms are present, the appropriate plan POWER Account will apply and available account dollars may be used to cover costs.

Frequency and age restrictions do not apply to preventive care services. This allows doctors to prescribe the preventive care services that are appropriate for you. (Note: Some immunizations are only FDA approved for certain genders and ages.) The following is an overview of the types of preventive services covered:

Required Preventive Services for Roll Over of POWER Account Funds

All members – annually:
Preventive Care Counseling Office Visit
Physical exam
Flu shot
Diabetes Screen

Males over 35:
Cholesterol Testing - annually

Females:
Over age 45 – Annual Cholesterol Testing
Age 40-50 – every 2 years Mammogram
Over age 50 – Annual Mammogram
All woman – Annual Pap Test

Immunizations:
Every 10 years - Tetanus, Diphtheria, Pertussis - 1 dose Td booster
(Refer to CDC Recommendations for further information)

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

The Anthem Blue Cross and Blue Shield Healthy Indiana Plan will pay for your preventive services and up to $500 per benefit period will not be charged to your POWER Account. At the end of the year if all age and gender appropriate preventive services have been received, any amounts remaining in your POWER Account up to the entire account balance (including the state's portion) rolls over to the next benefit period. This means you will owe less for your health care in your second year. However, if you don't get your recommended preventive health services, only the unused amount you contributed will roll over to the next benefit period. The state's portion will go back to the state.

Take this chart with you to the doctor. Ask if you are up-to-date or if you need any other exams, tests, shots, or counseling.

Anthem Blue Cross and Blue Shield Healthy Indiana Plan

a health plan sponsored by the State of Indiana

You must obtain services In-Network. Non-Network services are not covered, except Emergency Care and Family Planning Services.

Plan Benefits Guide

	In-Network
Annual Maximum	$300,000
Lifetime Maximum	$1,000,000
POWER Account (The POWER Account is 12 consecutive months from the 1st of the month in which the policy is effective)	$1,100
Emergency Care Childless adult - $25 Adult parents - <100% Federal Poverty Level - $3 100-150% Federal Poverty Level - $6 151-200 Federal Poverty Level - $25	Paid from POWER Account first and then 100% coverage after co-pay where indicated. Non-caretaker members have co-pay of $25. Caretaker members have copay of $3, $6 or $25 (see ID Card) which is waived for true emergency. Note - You should call your primary doctor for advice before going to the emergency room if you are not sure it is a true emergency. You can also call the 24/7 Nurse Line at 1-866-800-8780 to talk to one of our nurses. Go directly to the emergency room if you are having chest pains, or any other symptoms of a possible life threatening or serious health situation.
Preventive Care Services: Office Visits such as annual physicals Routine care such as immunizations, flu shot and cholesterol test **Screening Services:** Mammograms, chlamydia screening, blood glucose screening, Pap Smears, PSA, digital rectal exams and lead screening **Colorectal Cancer Screenings:** Fecal Occult Blood Screening Flexible Sigmoidoscopy, colonoscopy or radiologic imaging **Smoking Cessation Counseling**	First $500 per benefit period not charged to POWER Account Remember you must have all of your required preventive services each benefit period in order for all of the balance in your POWER Account to roll over to the next year.
Family Planning Services	Paid from POWER Account first, then 100% coverage from Anthem. Includes contraceptives and sexually transmitted disease testing
Prescription Drugs Retail: 30 days supply	Paid from POWER Account first, then 100% coverage from your insurance benefits. Prescription drug benefits are administered by the State. Call 1-866-879-0106 for prior authorization of prescription medication. Generic drugs are required, if available.

You must obtain services In-Network. Non-Network services are not covered, except Emergency Care and Family Planning Services. There are many different Anthem provider networks - be sure to use providers in the Anthem Healthy Indiana Plan and Buy In Level 1 Network. Call our Member Helpline at 1-800-553-2019 for assistance or go to www.anthem.com/healthyindiana.

Plan Benefits Guide

Human Organ and Tissue Transplant Services	Paid from POWER Account first, then 100% coverage from Anthem.
Inpatient Hospital Care **Outpatient Hospital Care** **Physician Office Visits** **Outpatient Diagnostic X-Rays/Lab Tests** Doctor's office visit/outpatient hospital visit **Inpatient and Outpatient Mental Health** **Medical Supplies, DME and Prosthetics** **Outpatient Therapy Services** Maximums per benefit period: Physical Therapy - 25 visits Occupational Therapy - 25 visits Speech Therapy - 25 visits **Ambulance** (Emergency transportation only. Non-emergency is not covered.)	Paid from POWER Account first, then 100% coverage from Anthem.
Maternity Care **Dental** **Vision**	Not Covered. It is easy for members who become pregnant to move to Hoosier Healthwise Package B for complete medical and maternity coverage. Just complete a Change Form and submit with proof of pregnancy to the state. You can re-apply to come back to the Healthy Indiana Plan after your pregnancy.

If you have questions, please call toll-free 1-800-553-2019.

POWER Account

With the Healthy Indiana Plan, you receive an annual allocation in your POWER Account for you to spend the way you want on covered health care expenses. The POWER Account is made up of contributions from you and from the state, and possibly from your employer. The funds in this account are used to cover the expenses that would normally be considered your deductible so this means under the Healthy Indiana Plan, you don't have any out-of-pocket costs that must go to a deductible. On the date your coverage becomes effective the state will place their annual commitment of funds into your POWER Account. The state will also determine how much you must contribute to the POWER Account and Anthem will send you a monthly bill for 1/12th of that amount during your enrollment in the plan. However, you get credit for the entire $1,100 on day one, that means on the day your coverage becomes effective, your POWER Account is fully funded even though your contributions will be collected over the next 12 months of your benefit period. The plan also includes Traditional Health Coverage – which helps protect you against further health care expenses. In addition, the Healthy Indiana Plan provides access to personalized health services and online tools to help you manage your health, health decisions and health care dollars. Go to www.anthem.com and sign up for MyAnthem.

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

POWER Account Contributions

Your Contribution:

- This is the portion of the POWER Account that you must pay. The state will determine this amount and you will pay 1/12th, in equal amount each month over the 12 month enrollment period, so at the end of the year you have met your contribution requirement. However you will receive credit for the entire annual amount on the date your coverage becomes effective so the funds will be available for paying claims for covered benefits that you receive. If you leave the plan early you must still pay the remainder of your portion of the POWER Account for the period you were enrolled.

State Contribution:

- The state will determine the amount you will pay and the state will then fund the remaining portion of the $1,100 that will be placed in your POWER Account.

Employer Contribution:

- Employers may choose to contribute up to 50% of the member's annual contribution to the POWER Account. This would then reduce the monthly amount you are required to pay. For information on the procedure and terms of the employer contribution, call the number on the back of your Healthy Indiana Plan ID card. The information will be sent to you and you can discuss it with your employer.

The Healthy Indiana Plan design is a modification of Anthem's Lumenos Consumer Driven Health Plan. The consumer driven health plans use the term Health Incentive Account (HIA) to describe a portion of the plan benefits and to explain where funds are made available to pay for covered services. You may see the term Health Incentive Account or HIA in this document and when you do, it will always mean the same thing as your POWER Account.

Most consumer driven health plans have a deductible. After the deductible is met, then the traditional insurance part of the Healthy Indiana Plan coverage will be used to pay for covered services received up to the annual benefit maximum or the lifetime maximum whichever occurs first. With the Healthy Indiana Plan your POWER Account amount has been set to a level that covers the entire deductible. The funds in the POWER Account will be used to pay for the cost of covered services the member receives during the plan year. So remember, when you see a reference to the deductible, the funds needed to meet your deductible are included in your POWER Account.

Q: How does the POWER Account work?

A: Here's how it works:

- First use your POWER Account funds to pay for covered medical expenses and prescriptions. The account dollars you use apply toward your plan's deductible.
- When you have used all the funds in your POWER Account, the traditional insurance part of the coverage begins and all covered services are paid at 100% except for the copay on emergency room services.
- The first $500 of preventive care services are paid by your insurance - they do not impact your POWER Account and there are no out-of-pocket costs to you, as long as you receive care from a provider that participates in the Healthy Indiana network (an in-network provider).
- All you need to do is present your identification card at time of service. The correct amount will automatically be deducted from your POWER Account when the claim is adjudicated.

Q. How do I make contributions to my POWER Account?

A. After you make your initial contribution, you may choose the best payment option for you. You have the choice between the following payment options:

- **Automatic Bank Draft** - If you choose this method, please submit the automatic bank draft form along with a blank voided check.
- **Check or Money Order** - Payments made by check or money order should be mailed to: Anthem BCBS, IN HIP, P.O. Box 105674, Atlanta, GA, 30348-5674. The remittance slip should be included in the envelope with the payment. Please include your account number in the memo section of the check or money order. If paying for multiple Healthy Indiana Plan members on the same check, a remittance slip should be included for each member.
- **Credit Card** - You must call customer service each time you wish to pay by credit card at **1-800-553-2019.**
- **Cash** - Cash payments are accepted IN PERSON for both the initial payment and monthly payments at the following National City Bank: Plaza Office, 101 West Washington St., Indianapolis, IN, 46255, 317-267-7906. PLEASE, DO NOT MAIL CASH. For more information about cash payments, please contact: Martha Moeller, Branch Manager or Eric Nicholson, Office Manager. As always, please remember to get a receipt of payment.

Q. WHAT IF I DON'T USE $1,100 OF SERVICES? WHAT HAPPENS TO THE MONEY IN MY POWER ACCOUNT?

A. At the end of the year, if you have received all age and gender appropriate preventive services, the entire account balance (including the state's portion) will roll over to the next benefit period. This means you will owe less for your health care POWER Account contribution for the next benefit period. However, if you don't get your recommended preventive health services, only the unused amount you contributed rolls over to the next benefit period. The state's portion will go back to the state.

Pregnant Women

No pregnancy related procedures are covered under HIP. If you become pregnant while a Healthy Indiana Plan Member, you will simply need to submit a Change Form and proof of pregnancy to transfer to Hoosier Healthwise Package B, where your pregnancy and all health care needs will be covered. You will need to provide evidence of pregnancy, per Indiana State requirements.

- All medical services for you, pregnancy and otherwise, will be covered by Package B of Hoosier Healthwise.
- Any POWER Account balances will be returned on a prorated basis.
- You may re-enroll in HIP following your pregnancy.

Anthem Blue Cross and Blue Shield serves Hoosier Healthwise Members in Indiana.

Hoosier Healthwise is a health program for Indiana children, pregnant women, and low-income families. Health care is provided at little or no cost to Indiana families enrolled in the program.

Anthem Features for Hoosier Healthwise Members

- Medical coverage, including vision and mental health
- Many doctors to choose from; AND changing doctors is easy
- Prescription drugs
- A special program for pregnant women
- Sports physicals for children with your assigned provider
- Well-Child visits and vaccines
- Transportation services

We're Nearby to Help

Anthem has community resource teams that help members:

- In their language.
- Find a doctor who speaks their language.
- Fill out forms.
- Connect to other services and free health classes in their area.
- By visiting them at their home, when they ask.

We Can Help in Many Ways

Along with our local community resource teams and phone support, Anthem offers:

- A 24-hour nurse help line to answer health questions, plus special nurses trained to talk to teens.
- Local classes and programs about healthy living, at no cost to members.
- Kits to teach kids how to eat well and stay active, at no cost to members.
- A helpful booklet for pregnant members, at no cost to them.
- A gift card for pregnant women who see their assigned doctor for a pregnancy checkup within 42 days after joining our health plan.
- A reward for new mothers who complete their postpartum visit with their assigned doctor 21 to 56 days after childbirth.
- A gift for getting your baby immunized and completing well-child doctor visits.

We're here to help!

Call 1-800-889-9949 to get information about the Hoosier Healthwise program.

NOTICE OF PRIVACY PRACTICES

Effective July 1, 2007

We can translate this at no cost. Call 1-866-408-6131; TTY 1-866-408-7188.

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

Please read this carefully.

This notice tells you who can see your Health Information with your ok and who can see it without your ok. It also tells what rights you have to see and MANAGE your information.

Your health and financial information are personal and private. The law says that we must protect this information of our current and former members. We get information about you from the Office of Medicaid Policy and Planning and the Office of Children's Health Insurance Program after you become eligible and enroll in our health plan. We also get medical information from your doctors, clinics, labs, and hospitals so we can approve and pay for your health care. Federal law says that we must give you this notice to help you understand what our legal duties are and how we will protect your verbal, written, and electronic health information using these methods:

- Physical (files)
- Technical (passwords)
- Procedural (policies to make sure your records stay safe)

When is it OK for us to use and share your health information?

We can use and share your information without your OK in some cases. Here are some examples:

For Your Medical Treatment

- To help doctors, hospitals, and others get you the care you need

For Payment

- To share information with the doctors, clinics, and others who bill us for your care
- When we agree to pay for medical care or services before you get them

For Health Care Operations

- To help with audits, fraud and abuse programs, planning, and day-to-day work
- To review our programs and try to make them better

For Public Health Reasons

- To help public health officials stop the spread of disease or prevent an injury

To Others Acting for You

- If you tell us it is OK, we can share your health information with your family or a person chosen by you who helps with, or pays for, your health care
- If you cannot speak for yourself and it is best for you, we can share your medical information with someone who helps with, or pays for, your health care

Other Uses Allowed or Required by Law

- To help the police and other people who enforce the law
- To obey laws about reporting abuse and neglect
- To help the court when asked to do so
- To respond to legal documents
- To give information to health oversight agencies for actions such as audits or exams
- To help coroners, medical examiners, or funeral directors find out your name and cause of death
- To help when you have asked to give your body parts to science
- To use for research
- To prevent or lessen a serious threat to health and safety
- To help government officials for special government functions
- To give information to workers' compensation for a work-related illness or injury

We will get an OK from you in writing before we use or share your health information for reasons not listed in this notice. You may tell us in writing that you want to take back your OK to share information. We can't take back what we used or shared when we had your OK, but we will stop using or sharing your information in the future.

What are your rights?

- You can ask to look at your health information and get a copy of it. Keep in mind that we do not have a complete medical record about you. **If you want a copy of your complete medical record, you should ask your doctor or health clinic.**
- If you think that something is missing from, or wrong in, your health record that we have, you can ask us to make changes.
- You can ask us not to share your information in some instances. However, we do not have to agree to your request.
- You can ask us to mail health information to an address that is different from your usual address or to send the information to you in another way. We can do this for you if sending to your usual address may put you in danger.
- You can ask us to give you a list of the times (after April 14, 2003) that we have shared your health information with someone else. This will not include the times we have shared your information for the purposes of treatment, payment, health care operations, or certain other purposes.
- You can ask for a paper copy of this notice at any time, even if you asked for a notice by e-mail.

What are our responsibilities?

- By law, we must keep your health information private except as listed in this notice.
- We must give you this notice that explains our legal duties about privacy.
- We must follow what we have told you in this notice.
- We must agree, when you make reasonable requests and you are in danger, to send your health information to a different address or to send it in a way other than regular mail.
- We must tell you if we cannot agree when you ask us to limit how your information is shared.
- If state laws are more strict than the rules in this notice, we will follow those laws.

What if you have a complaint?

If you think that we have not kept our promise to protect your health information, you may complain to us or to the Department of Health and Human Services. Nothing bad will happen to you if you complain.

Contact Information

If you have questions, complaints about our privacy rules, or want to apply your rights, please call us at **1-800-553-2019.**

We are here to help. If you still feel that we have not protected your privacy, you also may file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services.

We reserve the right to change this notice and the way we protect your health information. If that happens, we will tell you about the changes in a newsletter. We also will post them on our website at **anthem.com.**

As we told you in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use, and share nonpublic personal information (PI) as described in this notice. Your PI tells us who you are and is often gathered in an insurance matter.

- We may use your PI to make judgments about your:
  - Health
  - Money
  - Character
  - Habits
  - Hobbies
  - Reputation
  - Career
  - Credit

- We may collect PI about you from other persons or groups such as:
  - Doctors
  - Hospitals
  - Other carriers

- We may share PI with persons or groups outside of our company without your OK in some cases.
- We will contact you if we take part in an action that would require us to give you a chance to opt out.
- We will tell you how you can let us know that you do not want us to use or share your PI for a given action.
- You have the right to access and correct your PI.
- We take safety measures to protect the PI we have about you.

You can ask for a state notice that is more detailed. Please call the Customer Care Center at 1-800-553-2019; TTY 1-866-408-7188.

Some definitions—so we're all on the same page.

POWER Account – (also referred to as the Health Incentive Account (HIA)) The Personal Wellness and Responsibility (POWER) Account is a funded account the Member may use to offset the cost of any Covered Services as they meet the benefit plan POWER Account. If available, Anthem will automatically use funds from the POWER Account to offset the member's responsibility under the POWER Account (except for required copayments). The POWER Account/HIA will be funded with post-tax dollars from the state and the Member and are not considered a Health Spending Account or any other type of tax-preferred health spending accounts under federal law. Based on the Member's income level, the state will determine the Member's required Contribution amount for the benefit period. Each year the Member is enrolled, the state will contribute the difference between the amount of the POWER Account and the Member's required annual Contribution amount. Monthly, the Member must send Anthem 1/12th of the Member's annual required Contribution amount. Failure of the Member to contribute the required monthly amount to the account in a timely manner will result in the Member's termination from the Plan. At the end of the benefit period, a portion or all of the unused funds in the POWER Account/HIA (the "roll over" amount) may be made available to offset the Member's required annual POWER Account/HIA Contribution for the next plan year. The roll over amount available to offset Contributions in the next year will be determined by the state based on the Member completing a defined and required set of preventive services for the Member's age and gender. Note that roll over amounts are not calculated until 180 days after the end of the benefit period to allow time for submission of claims. In the event your income level changes during the Benefit year, you are permitted to request a re-determination of your required annual POWER Account/HIA Contribution amount.

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

A **copayment** is your portion of the cost for health care services received at a hospital emergency room. The co-pay amount is listed on your Anthem ID card (it is either $3, $6 or $25). If you are admitted as an inpatient from the emergency room you will not have to pay the co-pay. Also, if you are a caretaker member, you do not have to pay the co-pay if your medical situation meets the prudent lay person guidelines to be considered a true emergency.

A **drug formulary** is a list of medications that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. You are required to use medications on the formulary list unless your doctor requests an authorization for different medication by calling the number on the back of your ID card for pharmacy prior authorization.

Information about our Network Providers.

Using our network. You must use Anthem Healthy Indiana Plan and Buy In Level 1 network providers except for a true emergency in a hospital emergency room. You can also go to non-network providers for Family Planning services as long as they are contracted with the State of Indiana as a Medicaid provider.

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

Accessing Covered Services. Some services, or supplies, such as prescription drugs, require your doctor to receive an authorization from Anthem that defines and/or limits the conditions under which the service, or supply, will be covered to help you avoid any unnecessary out-of-pocket expenses. Other services, such as organ transplants, require your physician to certify, and for us to approve the service as medically necessary and the appropriate setting. Neither process is a guarantee of coverage.

Non-network provider. Charges from non-network providers will not be paid, except Emergency Room and Family Planning and prior authorized services. Providers not contracted with the Anthem Healthy Indiana Plan can bill you for their services. However, those providers contracted with the State of Indiana (IHCP) can not balance bill Healthy Indiana Plan members unless they specifically give you notice in advance that you will have to pay for the service. The notice must be specific and you must sign to agree to have the service knowing you will be responsible for paying the charge.

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

Our appeal rights and confidentiality policy.

If we deny a claim or request for benefits completely or partially, we will notify you in writing. The notice will explain why we denied the claim/request and describe the appeals process. You can appeal decisions that deny or reduce benefits. We encourage you to file appeals right away when you first get an initial decision from us, but we require that you file within 30 days of getting one. You should send additional information that supports your appeal and state all the reasons why you feel the appeal request should be granted. We will review your appeal and let you know our decision in writing within 20 days of receiving your first appeal. If you are denied coverage based on medical necessity or experimental/investigative exclusions, you can request that a board eligible or board-certified specialist review your appeal. If we deny coverage for reasons other than medical necessity or experimental/investigative reasons, you can also appeal. Please call customer service or check your contract or certificate of coverage for more information on our internal appeal and external review processes. Unless our notice of decision includes a different address, send requests for a review of appeal to:

Anthem Blue Cross Blue Shield Healthy Indiana Plan
P.O. Box 6144
Indianapolis, IN 46209-9210

Medicaid Hearing and Appeal Process

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

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

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

Indiana Family Social Services Administration
Hearing and Appeals Section, MS-04
402 W. Washington St., Room W392
Indianapolis, IN 46204-2773

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

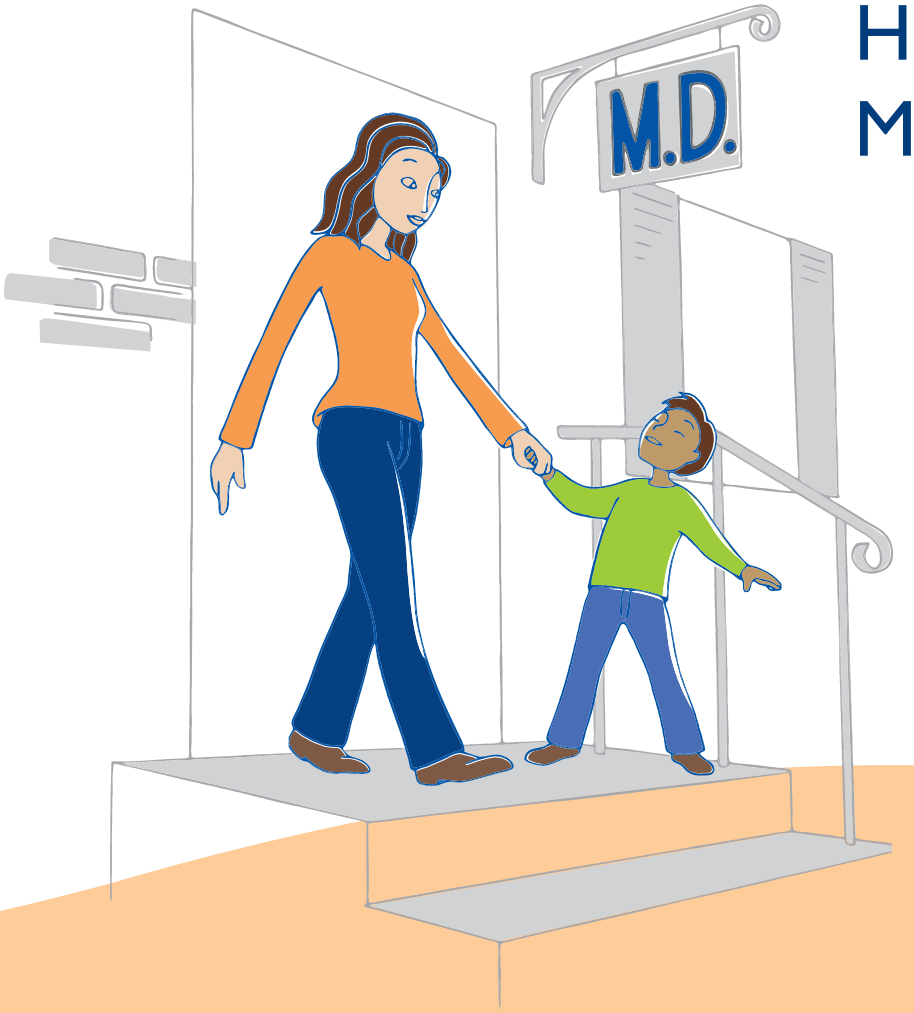
How to avoid Balance Billing. We will work with you to protect you from being balance billed for services when you do not use a network provider as long as the provider is contracted with the state of Indiana as an Indiana Health Care Provider (IHCP). These providers can not bill you the difference between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

Anthem®
Health. **Join In.**

HIP
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

This brochure is only a summary of benefits. It isn't part of the Healthy Indiana Plan Member Handbook. The Healthy Indiana Plan Member Handbook you will receive if you're approved for coverage includes all the details of the plan. In the event of a conflict between the information in this brochure and your Healthy Indiana Plan Member Handbook, the terms of your Healthy Indiana Plan Member Handbook will prevail. Read your Healthy Indiana Plan Member Handbook carefully. Anthem has the right to rescind, cancel or terminate your coverage based on provisions described in the Healthy Indiana Plan Member Handbook.

MDwise



Healthy Indiana Plan Member Handbook

HIP

HEALTHY INDIANA PLAN℠

Health Coverage = Peace of Mind

Welcome to MDwise!

Dear MDwise Member:
Welcome to the Healthy Indiana Plan! Your Healthy Indiana Plan is MDwise. You will get health care benefits from this plan.

Five Basic Rules

Now that you're a member, you should always follow these basic rules:

1. Carry your MDwise with you at all times. Show your card every time you get health care.
2. Contact your Primary Medical Provider for all medical care.
3. Only use the emergency room for true emergencies.
4. You must get preventive health care and check-ups each year that you have coverage.
5. You must pay your monthly contribution to stay in this health plan.

This handbook explains your benefits. Please call us with any questions.

Please read this handbook carefully.

Some pages have "**TIP**" boxes. These boxes have good advice to get the most out of your new benefits.

Call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196. There are representatives that can help you. If you should get an automated message after-hours, please leave your name and number and someone will return your call no later than the next business day. You can also visit **www.MDwise.org** for news and information.

Thanks!
Wishing You Good Health,
MDwise Customer Service Department

You Must Call Now to Activate Your Extra Benefits!

When you call, your customer service representative will:

- Welcome you to the MDwise plan and answer your questions.
- Tell you about your benefits.
- Tell you about special incentive programs and health programs.
- Ask you a few questions to find out about your health needs.
- Provide information about extra services besides health care, especially if you have special needs.
- Make sure that we have the correct address and phone number for you.

It will only take a few minutes, but it will help us to serve you better—and you'll learn about your plan BENEFITS! PLEASE CALL TODAY!

MDwise Customer Service Department: 1-877-822-7196 or in the Indianapolis area 317-822-7196.

Si quiere que le mandemos esta información en español, favor de llamar a nuestro departamento de Servicio al Cliente de MDwise al 1-877-822-7196 o en Indianápolis 317-822-7196. Gracias.

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PLEASE CALL THE MDWISE CUSTOMER SERVICE DEPARTMENT WITH ANY QUESTIONS ABOUT THIS HANDBOOK OR YOUR NEW BENEFITS 1-877-822-7196 or in the Indianapolis area 317-822-7196.

You can also visit the MDwise Web site: **www.MDwise.org.**

Welcome to MDwise!

HOW TO USE YOUR POWER ACCOUNT

As a member of the Healthy Indiana Plan, there are special rules to follow. Once you are eligible for the Healthy Indiana Plan, you will get a letter that will let you know what your monthly contribution is. You must pay this each month. If you do not pay this, you will be **disenrolled** from the program. We will send you a statement each month to remind you. If you are disenrolled due to non-payment, you cannot re-enroll for 12 months and there will be a 25% penalty on your POWER Account.

If a HIP member is disenrolled due to their death, MDwise will refund the POWER Account to the member's estate without penalty. This is done within 60 days of receiving notice of the member's death.

There are a number of ways you can make your monthly POWER Account contribution:

1. **Check or Money Order.** Make your check or money order payable to MDwise and mail your payment to:

   MDwise
   P.O. Box 713194
   Cincinnati, Ohio 45271-3194

   You can also pay by check or money order **in person** at:

   MDwise/ACS
   4550 Victory Lane
   Indianapolis, IN 46203

   Important note: All checks and money orders are held for 10 days to allow them time to clear. Please keep this in mind when mailing your contribution.

   If you do not have enough money in your bank account to cover the payment that you make, you will have an additional fee to pay. You will have to pay an $8.50 fee if your check bounces. This is in addition to making your monthly payment again.

2. **Cash.** Please do not mail cash. Cash, check or money order payments can be made **in person** at Key Bank locations, statewide. Please call Customer Service to find participating Key Bank branches, as all branches will NOT be participating.

   When paying by cash, you must have your initial payment letter or monthly invoice for payment to be accepted.

3. **Employer Contribution.** Ask at work if your employer is willing to pay part of your contribution. If so, your employer has to fill out the Employer Contribution Form. You can call Customer Service to give us the name and phone number of your employer. We will then contact your employer for you. Only a part of your contribution can be made by your employer. You will get a bill each month for the rest.

4. **Payroll Deduction.** Ask at work if your employer is willing to take your contribution from your check. If so, your employer has to fill out a Payroll Deduction Form. You can call Customer Service to give us the name and phone number of your employer. We will then contact your employer to get this set up.

For you to keep your Healthy Indiana Plan coverage, you must pay your POWER Account contributions by the due date on the bill you get each month. If your employer agrees to pay a part of your contribution, and then does not make that payment, we will let you know. You will then have 60 days to pay it yourself.

The Healthy Indiana Plan will add the rest of the funds that you will need to get health care services. This money will go into a POWER Account. POWER Account stands for Personal Wellness Responsibility Account. You will have $1,100 in your POWER Account. You will get a MDwise card in the mail. Use this MDwise card whenever you go to the doctor, the pharmacy or anytime that you get health care services. Except for your preventive care, other medical services will be paid for by your POWER Account. When the cost of your medical services is more than $1,100, MDwise will cover the costs.

This plan does have some limits. They are:

- $300,000 per year
- $1 Million dollars in a lifetime

HOW TO USE YOUR POWER ACCOUNT continued

It is important to remember that preventive care is covered. The Healthy Indiana Plan will cover all preventive care. Please see **Pages 7 and 8** for more information about the preventive care that you need to get. If you get the preventive services you need by the end of the year, and you have money left over in your POWER Account, that money will be rolled over to your POWER Account for next year! If you DO NOT get the preventive care that you need, any state contribution money left over at the end of the year will not roll over to the next year.

If you have any questions about your new POWER Account and to find out how much is in your account, please call MDwise Customer Service at 1-877-822-7196, or in the Indianapolis area 317-822-7196.

How to Know What Medical Service Cost Your POWER Account.

It is important to know what your medical services cost. That way you will know how much is going to be taken out of your POWER Account each time you get medical care. Please visit the MDwise Web site at **www.MDwise.org** for a list of medical services and their costs. You can also call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area, 317-822-7196, and we can mail you a list of services and their costs.

MDwise Healthy Indiana Plan Benefit Summary

Annual Maximum	$300,000
Lifetime Maximum	$1,000,000
POWER Account	$1,100
Emergency Care	$3–$25 member copay; Copay is not required if ER visit is a true emergency or if you are admitted
Preventive Care - annual check-ups; annual screenings recommended by your PMP and according to preventive care guidelines for your age and gender	MDwise pays at 100%
Family Planning	Paid from POWER Account; Then MDwise pays 100%
Prescription Drugs	Paid from POWER Account; Then State pays 100%
Inpatient Hospital Care Outpatient Hospital Care Physician Office Visits Outpatient Diagnostic X-rays and Lab Tests Inpatient and Outpatient Mental/Behavioral Health Medical Supplies, DME and Prosthetics Outpatient Therapy Services Ambulance (Emergency Transportation Only)	Paid from POWER Account; Then MDwise pays 100%
Organ and Tissue Transplant Services	Paid from POWER Account; Then MDwise pays 100%
Pregnancy Services, Dental, Vision	Not Covered
Out of Network Services (Except for Emergency Care and Family Planning)	Not covered

MEMBER REDETERMINATION

Healthy Indiana Plan members must re-enroll every 12 months. This is also called redetermination. The process will determine if you are still eligible. It will also determine what monthly amount that you need to pay for the next year.

90 days before your coverage ends, you will get a letter from the Division of Family Resources with information on how to enroll for next year. Please read this information VERY carefully! If you have questions about it, feel free to call us at 1-877-822-7196 or in Indianapolis, 317-822-7196.

60 days before your coverage ends, you will get another letter from the Division of Family Resources with a re-enrollment form. You must fill out this form completely and mail back to:

FSSA Document Center
P.O. Box 1630
Marion, IN 46952

You can also fax the completed form to: 1-800-403-0864.

It is very important that you fill out the re-enrollment form right away and send it in! The Division of Family Resources must get this completed form 45 days BEFORE your coverage term ends or you will be disenrolled from HIP. You will not be able to re-enroll for 12 months.

If you need help to fill out this form, please call us and we would be happy to help you! Also, if you do not get this form by 60 days prior to your re-enroll date, call 1-877-438-4479 to request a new one be sent to you.

GETTING MEDICAL SERVICES

You chose or were assigned to MDwise. Your MDwise doctor is called your Primary Medical Provider (PMP). PMPs can be one of four types of doctors:

- Family practice doctor
- General medicine doctor
- Internal medicine doctor
- Gynecologist doctor–for women only

Some PMPs work with trained health care assistants. The types of assistants that may help your PMP are:

- Nurse Practitioners
- Physician Assistants
- Medical Residents

These assistants can do many health care services that your doctor does. They can take medical histories, complete physicals, order lab tests, and give you health education.

If you would like to learn more about these assistants, or would like to see one of these assistants at your doctor's office, please call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area 317-822-7196.

Your MDwise Doctor Will Handle All of Your Health Care.

This includes:

- Giving check-ups and immunizations (shots)
- Giving routine care
- Writing prescriptions
- Referring you to specialists or other providers
- Admitting you to the hospital

You should call your doctor whenever you need care.

Visit Your Doctor First

As a MDwise member, you must get most health care through your assigned doctor. This way, your doctor can organize all your health care services. This helps you be as healthy as possible.

Always call your doctor when you need medical care. Your doctor has someone who can help you 24 hours a day.

If you get sick after hours, call your doctor's regular office number. If you hear a message, listen for instructions on what to do.

Sometimes, your doctor may want you to get care from other providers. When this happens, your doctor will give you a written okay. This will let you go to another doctor or to a hospital or lab. **This written okay is called a referral.** Your doctor will give you a referral to visit another MDwise doctor. If we do not have the doctor you need in MDwise, then we will find you a doctor outside of MDwise that can help you.

TIP:

New MDwise members should call to make an appointment with their doctor right away. Make an appointment with your new doctor in the first 3 months or 90 days. You should make an appointment even if you are not sick. You can ask to have a physical exam and talk to your doctor about any other preventive care that you need to get. This is also a good way to get to know your new doctor so he or she can take better care of you-before an emergency happens!

HOSPITALS

You may need to go to the hospital at some time. Your doctor will set this up for you. You should not go to the hospital without your doctor's okay. This is very important. Otherwise, MDwise may not cover your hospital care.

Choosing a Hospital

Your doctor only treats patients at a certain hospital. You should only use the hospital that your doctor uses. Ask your doctor first!

Examples of when you should use your doctor's hospital:

- When you have planned surgery
- When your doctor wants to admit you for other reasons

However, if you have a true emergency, you do not have to call your doctor. Just go to the nearest hospital for immediate care.

Remember that you must pay a copay when you use the emergency room.

TIP:
Ask your doctor which hospital to use before you need it. Always use that hospital, unless it is a true emergency. Then, just go to the closest hospital right away.

Special Situations

What Do I Do If There Is An Emergency?
You should call your doctor whenever you have questions or need care. This is the best way to help your doctor take care of you. However, if it is an emergency, do not wait to call your doctor first!

Call 911 or go straight to the nearest hospital emergency room.

You can read more about emergency care on **Page 13**.

What Do I Do When I Am Far From Home?
If you are far away from home, you should still call your doctor if you need care. He or she can help you get routine or urgent health care.

If you cannot afford the long distance call to your doctor, we can help. You can call MDwise free of charge. We will help you reach your doctor.

TIP:
Your doctor should be available 24 hours a day! You should always be able to reach your doctor or your doctor's after-hours number. It is okay to call, even late at night, if you have an emergency or urgent health care needs.

Interpretation Services

MDwise doctors can talk to you in Spanish or other languages. This is a free service. It is available to you 24 hours a day, 7 days a week by phone and at doctor visits. You or your doctor can call MDwise Customer Service and these services will be arranged for you.

STAYING HEALTHY

Get Check-ups Regularly

It is important to get check-ups from your doctor every year. This is true even if you feel healthy. There are many reasons to get preventive care check-ups. The information you will learn will help you take charge of your health!

Check-ups will help you:

- Get immunizations (shots) that can help keep you from getting sick.
- Catch early warning signs before a disease or illness gets worse.
- Check "vital statistics" so your doctor can compare them when you do get sick.
- Get advice on eating better, quitting smoking, or other healthy living tips.

TIP:

Regular check-ups help you and your doctor get to know each other. This will help your doctor understand your needs when you are sick! Regular visits will help you feel that you can trust your doctor about your health.

Preventive Care for Adults

Adults need several kinds of preventive care, like:

- Routine exams and tests, as your doctor recommends. This may include mammograms or prostate exams.
- Annual pelvic exams, Pap tests and breast exams for adult females.
- Flu shots.

PREVENTIVE CARE GUIDE

Preventive Care

The following chart lets you know what care or screenings you may need for someone your age and gender. For example, if you are a 25 year old female, please find that row for the preventive care that you may need. Your doctor will know what preventive services you need. For those members that started HIP in 2008 and are in their second year of coverage and for new members in 2009, the following chart shows you the preventive services that you need to get in order to roll-over your POWER Account balance at the end of the year.

IF YOU ARE:	YOU NEED:
Male age 19-34	Annual Physical Exam Blood Glucose Screen* Tetanus-Diptheria Screen
Female age 19-34	Annual Physical Exam Pap Smear Blood Glucose Screen* Tetanus-Diptheria Screen
Male age 35-49	Annual Physical Exam Cholesterol Testing* Blood Glucose Screen* Tetanus-Diptheria Screen
Female age 35-49	Annual Physical Exam Pap Smear Cholesterol Testing* (if you are over 45) Mammogram Blood Glucose Screen* Tetanus-Diptheria Screen
Male age 50-64	Annual Physical Exam Cholesterol Testing Blood Glucose Screen* Tetanus-Diptheria Screen Flu Shot*
Female age 50-64	Annual Physical Exam Pap Smear Cholesterol Testing* Mammogram Blood Glucose Screen* Tetanus-Diptheria Screen Flu Shot*

**Annual or as required by your disease/history specific condition*

Please remember that all preventive care that you get is covered by MDwise. This will not be taken out of your POWER Account. If you get preventive services every year, and you have money left over in your POWER Account, that money will be rolled over to your POWER Account for next year! If you **DO NOT** get the preventive care that you need, any state contribution money left over at the end of the year will not roll-over to the next year.

MAKING DOCTOR APPOINTMENTS

Call for an Appointment

You should always call before visiting the doctor's office. When you call, the doctor's staff will schedule a time for you to see the doctor as soon as possible.

TIP:
Always call at least 24 hours before your appointment if you have to cancel it. The doctor's office will set up a new appointment for you. Calling will also let the doctor's office know they can give your appointment time to someone else.

Before You Call

When you need health care, you should call your doctor right away. When you call, you can also ask to talk to a nurse if you have medical questions.

Before you call, be sure that you:
- Have your MDwise Card handy
- Are ready to explain what is wrong
- Have a phone number where the doctor can call you later (this can be a family member or friend's number, if needed)
- Have a pen and paper ready to write down any instructions

Schedule Your Appointment

This list shows the longest you should have to wait to get an appointment:
- Within 2 months for a first appointment.
- Within 1 day, for urgent care (like a fever).
- Within 3 days, for non-urgent care (like ongoing knee pain).
- Within 3 months for an annual physical exam.

It is very important to keep your doctor's appointments. This helps your doctor take better care of you!

Getting Ready for Your Doctor's Appointment

Before you see the doctor, be sure to write down your questions. Never be afraid to ask questions. The doctor wants you to understand all your treatment decisions.

TIP:
Please call MDwise at 1-877-822-7196 or in the Indianapolis area 317-822-7196 if you have problems with waiting times or making an appointment.

If this is your first appointment with a doctor, plan to arrive early. The doctor's office may have paperwork for you to fill out before you see the doctor.

In the Waiting Room

You will have the shortest wait in the waiting room if you make an appointment first. Your wait time should be under one hour. Sometimes it may take longer if your doctor has unplanned emergencies.

COVERED MEDICAL SERVICES

MDwise wants to help you stay healthy. That is why we cover preventive care as well as sick care. **If there are changes to your benefits, we will let you know by mail**. If you have any questions about your benefits, please talk to your doctor or call MDwise at 1-877-822-7196 or in the Indianapolis area 317-822-7196.

Preventive Care

Getting regular preventive care is the key to better health. You get preventive care when you go to the doctor for check-ups and other well care. MDwise covers preventive care because it keeps you healthy and checks for problems before they become serious. Examples include:

- Check-ups and shots.
- Physical exams.
- Mammograms and Pap smears.

Necessary Care

Care must be "medically necessary." This means it is:

- Needed to diagnose or treat you.
- Proper based on current medical standards.
- Not more than what is needed.

Prior Authorization

Some services need approval from MDwise before you get them. This is called prior authorization. If your doctor does not get prior authorization when it is needed, MDwise will not pay for the services.

Prior authorization decisions are based only on the appropriateness of care and services. These decisions are also based on whether or not you have coverage. Doctors and staff that make prior authorization decisions do not get incentives or rewards for making these decisions. They do not get payment for deciding to deny a service or for making decisions that may make it harder to get care and services.

Services Your Doctor Must Approve and Refer You To

Members can get the full list of services on this page. Your doctor must approve all these services.

To get the following services, you must call or go to your doctor first. The doctor will refer you for any treatments you need:

Doctor Care:
Physical exams
Primary care
Preventive care
Specialty care

Hospital Care:
Inpatient services
Outpatient services
Diagnostic services
Lab tests and X-rays

Medical Supplies:
Prescriptions
Durable medical equipment
Hearing aids for 19 and 20 year olds

Other:
Immunizations (shots), health care screenings and diagnosis
Home health care therapy, including:
- Physical therapy
- Respiratory therapy
- Speech therapy
- Occupational therapy

Renal dialysis
Smoking cessation
Disease Management
Lead screening for 19 and 20 year olds
Hospice services
Skilled Nursing facility (60-day maximum)

If you have questions about your benefit package please call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196.

SERVICES FROM OTHER DOCTORS

Sometimes, you may need to see a provider other than your regular doctor.

Seeing a Specialist

A specialist is a doctor who treats one part of the body, like the heart, skin, or bones. Your regular doctor will write you a referral if you need to see a specialist. That specialist will be in the MDwise network.

If MDwise does not have the doctor that you need in our network, or that is not within 60 miles of your home, we may authorize out-of-network doctors to take care of you. These providers must be Indiana Health Coverage Program or Medicaid providers.

You Must Get a Referral from Your Doctor Before Going to a Specialist.

MDwise will not cover specialist care unless you have a referral from your doctor. Your doctor will tell you how to get specialist care.

Self-Referral Services

The following services are "self-referral" services:

- Emergency services
- Family planning

MDwise covers these services. Your doctor can help you get these services, but you do not have to go through your doctor to get them. You can go to any provider, who is an Indiana Health Coverage Program or Medicaid provider, to get these services. Self-referral providers must get an okay from MDwise before giving you some services.

Remember, your doctor can best take care of you if you talk to the doctor before getting any kind of health care.

Services Not Covered

The following services are not covered under the Healthy Indiana Plan:

- Services that are not medically necessary
- Maternity and related services *(see page 12)*
- Dental Services
- Conventional or surgical orthodontics or any treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly
- Vision services
- Elective abortions and abortifacients
- Non-emergency transportation services (i.e., transportation services that are unrelated to an emergency medical condition)
- Chiropractic manipulations such as back and spinal adjustments
- Drugs excluded from HIP
- Long term or custodial care
- Experimental and investigative services
- Day care and foster care
- Personal comfort or convenience items
- Cosmetic services, procedures, equipment or supplies, and complications directly relating to cosmetic services, treatment or surgery, with the exception of reconstructive services performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies or a previous medically necessary procedures
- Hearing aids (unless you are 19 or 20) and associated services
- Safety glasses, athletic glasses and sunglasses
- LASIK and any surgical eye procedures to correct refractive errors

- Vitamins, supplements and over-the-counter medications, with the exception of insulin
- Wellness benefits other than tobacco cessation
- Diagnostic testing or treatment in relation to infertility
- In vitro fertilization
- Gamete or zygote intrafallopian transfers
- Artificial insemination
- Reversal of voluntary sterilization
- Transsexual surgery
- Treatment of sexual dysfunction
- Body piercing
- Over-the-counter contraceptives
- Alternative or complementary medicine including, but not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, reike therapy, massage therapy and herbal, vitamin or dietary products or therapies
- Treatment of hyperhydrosis
- Court ordered testing or care, unless medically necessary
- Travel related expenses including mileage, lodging and meal costs
- Missed or canceled appointments for which there is a charge
- Services and supplies provided by, prescribed by, or ordered by immediate family members, such as spouses, caretaker relatives, siblings, in-laws or self
- Services and supplies for which an enrollee would have no legal obligation to pay in the absence of coverage under the plan
- The evaluation or treatment of learning disabilities
- Routine foot care, with the exception of diabetes foot care
- Surgical treatment of the feet to correct flat feet, hyperkeratosis, metatarsalgia, subluxation of the foot, and tarsalgia
- Any injury, condition, disease or ailment arising out of the course of employment if benefits are available under any Worker's Compensation Act or other similar law
- Examinations for the purpose of research screening

PREGNANCY CARE

The Healthy Indiana Plan does not cover pregnancy care. If you become pregnant while you are on the plan, please call MDwise Customer Service right away. All pregnancy services are covered under the Hoosier Healthwise Package B plan for pregnant women. You may be eligible for this plan. We can help you to sign up.

You must complete a "Report of Change" form and fax or mail to:

FSSA Document Center
P.O. Box 1630
Marion, IN 46952
Fax: 1-800-403-0864

You must also send proof of your pregnancy.

You will then be disenrolled from the Healthy Indiana Plan. At the end of your pregnancy, you can re-enroll in the Healthy Indiana Plan.

You can choose to stay in the Healthy Indiana Plan, but if you do this, your pregnancy services will not be covered.

Regular check-ups are important for a healthy baby so don't forget to call right away, so that you can get the care that you need! You can call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area 317-822-7196.

EMERGENCY CARE

No one likes to spend hours in an emergency room. You can help by getting preventive care. This way, you can get health care before the problem gets too bad. See **Page 8** for a list of preventive care services that are right for you.

MDwise will cover emergency care 24 hours a day. If you have a true emergency, go to the closest hospital right away. MDwise will cover your emergency care even if:

- You are far away from home.
- You cannot get to your doctor's regular hospital.

Post-stabilization services in the emergency room are also covered. The emergency room doctor will stabilize the condition that you went to the ER for. If the doctor decides that you need more testing or services, he/she can contact MDwise to get approval for more tests or services. This happens only after you are stable and are no longer in immediate danger.

Emergency Room Copay

Healthy Indiana Plan members must pay a copay when you go to the Emergency room. The copay is based on your level of coverage. Your copay can be from $3 to $25. Your copay is listed on your MDwise card. You **cannot** use your POWER account to pay for this copay.

If you are admitted to the hospital after your emergency room visit, you do not have to pay this copay.

Three Kinds of Care

There are different kinds of health care: preventive care, urgent care, and emergency care. This chart shows you what to do when you need each kind of care. If you have questions, always ask your doctor for advice.

KIND OF CARE	WHAT TO DO
Preventive Care - This is when you get regular care to keep you healthy. Examples are: • Check-ups • Annual exams • Immunizations (shots) • Prescriptions and refills	**Preventive Care** • You should always call your regular doctor to make an appointment for preventive care.
Urgent Care/Sick Visit - This is used when you need immediate care, but you are not in danger of lasting harm or loss of life. Examples are: • Earache • Sore throat • Fever • Minor cut that may need stitches	**Urgent Care/Sick Visit** • Call your doctor. The doctor will make you an appointment or give you other instructions. • You should not go to the Emergency Room for urgent care. • Even if it is late at night, your doctor always has someone who can talk to you and help.

Emergency Care - This is used when you have a serious medical condition and are in danger of lasting harm or loss of life if you do not go to the Emergency Room immediately. Examples are:
• Poisoning
• Severe head injury
• Excessive bleeding
• Convulsions
• Serious burns
• Loss of consciousness
• Sudden severe chest pains
• Trouble breathing
	Emergency Care
	• Go to the nearest hospital or call 911. You do not have to call your doctor first in an emergency.
	• When you get to the hospital, or as soon as you are able:
	  • Show them your MDwise card
	  • Tell them you are a MDwise member
	  • Ask them to call your doctor within 24 hours

Out-of-Area Care

If you are far away from home, you can still get health care. Before getting care, you must call your doctor. You can also call MDwise for help at 1-877-822-7196 or in the Indianapolis area 317-822-7196. If you have a true emergency, do not call first. Go straight to the nearest hospital.

After Hours Care

Even after-hours, you can call the doctor's regular office number. If you hear a message, listen for instructions on what to do. Most MDwise doctors will have someone "on call" that will call you back to answer your questions.

Your MDwise Card lists numbers you can call when you need help.

When to Go to the Emergency Room

- You should not use the ER for anything but true emergencies!
- If you are not sure if it is an emergency, call your doctor for advice.
- Your doctor has someone who can help 24 hours a day. If you hear a recorded message when you call, listen carefully for instructions.

TIP:

Always keep your MDwise Card in your wallet or purse. That way, if you need help, you will have our phone numbers close at hand.

BEHAVIORAL AND MENTAL HEALTH SERVICES

Many people think mental or emotional problems are rare. In fact, they are common. A mental illness or emotional problem can affect thoughts and behavior. It can make it hard to cope with normal life routines.

Covered Services

If you think you may have a mental or emotional problem, it is important to remember there is help. MDwise covers behavioral health services for our members. These services include:

- Mental health
- Behavior problems
- Alcohol and drug abuse

MDwise members can choose a behavioral/mental health provider and set up appointments without a referral from a doctor. However, you should always talk to your doctor. He or she can help you find the right behavioral health provider.

You must choose a behavioral health provider within the MDwise network. There is a list of behavioral/mental health providers that you can choose from. To find a behavioral/mental health provider you can call MDwise Customer Service or go to **www.MDwise.org**.

If you have any questions about behavioral and mental health services, call MDwise at 1-877-822-7196, or call 317-822-7196 if you are in the Indianapolis area. When you call you will be asked to pick a number from a list of options. Listen carefully and pick **option #2** for "behavioral or mental health services". If you have a behavioral or mental health emergency, there is an option that you can pick and someone will help you right away.

We can answer your questions!

PHARMACY SERVICES

Medicines for MDwise members are covered. You can go to any pharmacy that accepts Indiana Medicaid. If you have pharmacy questions or problems, please call 1-800-457-4584 and choose option #2.

How the Prescription Benefit Works

When you need medicine, your doctor will write a prescription. You can take that prescription to the pharmacy.

There are no copays for your prescription medicine. Your medicines are paid for through your POWER Account.

Over the counter medicines or vitamins are not covered under HIP unless they are on the preferrred drug list (PDL). See below for more information about the PDL.

Prescription Medicine

The Healthy Indiana Plan covers necessary medicines. Your doctor must prescribe these medicines. It must be a medicine approved by the Food and Drug Administration (FDA).

The Healthy Indiana Plan gives your health care provider a tool called a preferred drug list. This helps him or her prescribe drugs for you. A preferred drug list is a list of some of the brand and generic medicines covered by the Healthy Indiana Plan. MDwise Healthy Indiana Plan members can call 1-800-457-4584 and choose option #2 to ask about medicines that are covered. If you have Internet access, you can go to **www.indianamedicaid.com** or to **www.indianapbm.com.** This drug list will also show you any of the over-the-counter medicine and vitamins that are covered.

There is also the Indiana Medicaid Pharmacy Services Member Handbook. It is available online at **www.indianamedicaid.com** under Pharmacy Services or you may call 1-800-457-4584, option #2, to have a copy mailed to you.

If you need help, you can call MDwise Customer Service for help at 1-877-822-7196 (toll-free) or 822-7196 in the Indianapolis area. You can also visit **www.MDwise.org** to find a list of pharmacies. Please click on "find a provider" and choose the IHCP pharmacy directory.

TRANSPORTATION

Healthy Indiana Plan members can get ambulance transportation for true emergencies. You should only call an ambulance when it is a true emergency. If you think your problem could cause lasting harm or loss of life, call 911.

TIP:

Since non-emergency transportation is not covered under the Healthy Indiana Plan, here are some other ideas for gettting a ride to your doctor appointment:

- Ask a family member or friend to take you.
- Find a bus route or other public transportation to take you.

Remember, you must pay for these types of transportation. MDwise does not cover them.

SPECIAL HELP

MDwise has several ways to help us talk with special needs members. Instructions are shown below.

Hearing and Speech Impaired Members

1. Call the Relay Indiana Service at 1-800-743-3333. You can also dial "711". This number can be used anywhere in Indiana.
2. Ask them to connect you to MDwise: 1-877-822-7196 or in the Indianapolis area 317-822-7196.

Language Assistance

1. MDwise has customer services representatives that can talk to members in other languages. Please call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196.
2. The customer service representatives can also get an interpreter on the line if needed. The customer service representative and the interpreter will both help answer your questions.

Member Advocates

MDwise also has staff that can help you with difficult issues that you may have such as help in talking to your doctor, keeping appointments or finding other services, like a parent support group or help with food, housing or utility problems. These Member Advocates can help if you need suggestions or information about other services available in your community. We call this program HELPlink.

Advance Directives

Advance Directives are documents you can complete to protect your rights for medical care. It can help your family and doctor understand your wishes about your health care. You can:

- Decide, right now, what medical treatments you want or don't want.
- Give someone the power to act for you in a lot of situations, including your health care.
- Appoint someone to say yes or no to your medical treatments when you are no longer able.
- Inform your doctor, in advance, if you would or would not like to use life support systems, if ever necessary.
- Inform your doctor if you would like to be an organ donor.

These are the types of Advance Directives in Indiana:

1. Talking directly to your doctor and family
2. Organ and Tissue donation
3. Health Care Representative
4. Living Will Declaration or Life-Prolonging Procedures Declaration
5. Psychiatric advance directives
6. Do not Resusitate Declaration and order (out of hospital)
7. Power of Attorney

Advance Directives will not take away your right to make your own decisions. Advance Directives will work only when you are unable to speak for yourself.

MDwise cannot refuse care or discriminate against members based on whether they choose to have, or not to have, an advance directive. MDwise is required to follow State and Federal laws. Your MDwise doctor should document whether or not you have executed an advance directive in your medical record.

If you have concerns that a MDwise organization or provider is not meeting Advance Directive requirements, please call MDwise Customer Service.

SPECIAL MDWISE PROGRAMS FOR YOUR GOOD HEALTH!

MDwise has a number of extra programs for you and your family. They will help you get healthy and stay healthy. Special MDwise programs include:

NURSEon-call

Speak with a nurse 24 hours a day

Sometimes you have questions about your health. Just call our 24-hour phone line and speak with a nurse, not a recorded message. Call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196. Select option 3.

INcontrol

Learn to manage your asthma, diabetes or other chronic illness

WELLNESSchats

Fun, educational community events where you can learn about good health

HELPlink

Work with a member advocate who knows about health, school and community services

SMOKE-free

Get help kicking the tobacco habit

WEIGHTwise

Reach and maintain a healthy weight

If you have questions about any MDwise programs, call us at: 1-877-822-7196 or in the Indianapolis area 317-822-7196, or visit the MDwise Web site **www.MDwise.org**.

MDWISE CAN HELP

We want to answer all your questions about your new MDwise plan. If you have any complaints, we are here to help fix the problem. We want you to get the best health care and service possible.

There is a MDwise representative that can help you 8:00 a.m. to 6:00 p.m. (EST), Monday through Friday. After hours, you can leave a message and someone will call you back right away the next business day.

If you need your member handbook and other MDwise information in other ways let us know. Examples are if you need the information in larger print, Braille or on an audiocassette.

Please call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196, if you have good or bad comments! You can also visit the MDwise Web site at www.MDwise.org. Click on the Healthy Indiana Plan.

The next few pages have tips on how to handle changes or questions you might have about MDwise or your doctor. Keep this booklet handy in case you need help with one of these situations.

TIP:
MDwise members have certain RIGHTS and RESPONSIBILITIES!
A list of these is on **Page 25** of this handbook.

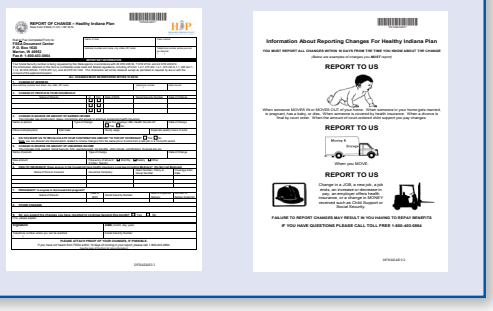
We want to provide high quality service to you. So, here is our promise to you:
- If you have a problem, we will be here to listen.
- We will do our best to fix the problem for you.

MAINTAINING YOUR MDWISE PLAN

New Address or Phone Number

If you move or change your phone number, you MUST call MDwise at 1-877-822-7196 or in the Indianapolis area 317-822-7196. You will need to fill out a "Report of Change" form. We can help you fill out this form.

"Report of Change" Form



Other Insurance Plans

If you have other health insurance, you must let us know. You are not eligible for the Healthy Indiana Plan if you have other health insurance. You must also tell us, and the Healthy Indiana Plan (1-877-438-4479), if:

- You have changes in your insurance
- You get hurt in a car wreck
- You get hurt at work
- You get hurt and someone else may have to pay

Changing Your Doctor

If you are not happy with your health care or your doctor, please call MDwise. We will work with you to fix any problems you have.

You are able to change your doctor once each year. You can only change for the following reasons:

- You have moved.
- Your doctor has moved or no longer belongs to MDwise.
- Your doctor does not return your calls.
- You have trouble getting the care you want or your doctor says you need.
- Your doctor was assigned by MDwise before you had the chance to choose a doctor for yourself.
- Other reasons–call for more information.

To change your doctor or to ask for a list of doctors in your area, please call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area 317-822-7196 or visit **www.MDwise.org** to get a list of MDwise doctors.

Remember, it is better for your health to stay with one doctor, rather than to change doctors often.

Changing Your Plan

We hope that you are happy with the services that you receive from MDwise. If you are not happy please call MDwise Customer Service and we will try to help.

You can change your plan:

- At the end of the year when you re-certify for the Healthy Indiana Plan
- If you become eligible for the ESP plan
- If there are quality of care problems that we cannot fix for you

Changing Your Contribution Amount

If you have a change in family size or income, call 1-877-438-4479 (1-877-GET-HIP-9). Let them know about the change. You can also call MDwise Customer Service and we will help you complete a change form.

What To Do if You Pay More Than 5% of Your Annual Income

Are you on the HIP program as a caretaker adult? This means that you are on HIP and you have children that live with you that are on Hoosier Healthwise or Care Select. If you are and you have paid for healthcare services over 5% of your income, let us know.

This money must have been paid for:

- Monthly contributions
- ER copays

If what you have paid for these things is more than 5% of your income in a 12-month coverage period, you may not have to pay future contributions to HIP or ER copays.

If you think this is true for you:

- You must collect and send in copies of all of your receipts
- We must confirm your income

Requests and documentation can be sent to:

MDwise Customer Service
P.O. Box 44236
Indianapolis, IN 46244-0236

We will review all of your documents. We will confirm whether you have paid over 5% of your income during a 12 month coverage period. We will then let you know the outcome of our review. Call MDwise Customer Service for more information at 1-877-822-7196 or in Indianapolis 317-822-7196.

What To Do if You Get a Bill for Health Care

MDwise only pays your provider for the covered services you get. A provider cannot require you, your relatives, or others to pay additional charges for these covered services.

Health care providers generally cannot bill Healthy Indiana Plan members unless it is for a non-covered service.

If you do get a bill for health care services, take care of it right away by following the steps below. Otherwise, it may be sent to a collection agency.

- Contact your health care provider to make sure they know you are on the MDwise Plan.
- Contact MDwise and tell them you received a bill.

Providers know the limits placed on their services. The provider must tell you if MDwise does not cover a service before the service is provided. A provider may charge you for services that are not covered by MDwise if:

- The provider told you before providing the services that the services are not covered.
- You agreed to pay for the service in writing.

Remember to take your MDwise Card with you to all health care appointments and show it to the office staff.

Help MDwise Stop Fraud and Abuse

- Do not give your MDwise Card number to anyone. It is OK to give it to: your doctor, clinic, hospital, pharmacy or MDwise Customer Service.
- Do not let anyone borrow or use your MDwise Card
- Do not ask your doctor or any health care provider for medical care that you do not need
- Work with your primary doctor to get all of the care that you need
- Do not share your Healthy Indiana Plan or other medical information with anyone except your doctor, clinic, hospital, or other health provider

Call MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area 317-822-7196, if you have questions or concerns about fraud and abuse.

YOUR OPINIONS

Member Surveys and Outreach

Your opinions matter to us! We do a member survey to make sure you are happy. This helps us improve our service. It also helps us give better health care for you. This survey is done once each year.

MDwise members may occasionally receive phone calls from MDwise. One type of call might be to ask questions about your health needs. Your answers help MDwise know which programs might be right for you. Another type of call might be to ask about your satisfaction with your doctor. A MDwise caller will tell you right away who they are and why they are calling. Your answers to our questions help us serve you better.

MDwise also does automated calls. These calls may include reminders about monthly contributions or they might be a reminder to get needed preventive care.

If you have any questions at any time about these calls or the survey, please call: MDwise Customer Service at 1-877-822-7196 or in the Indianapolis area 317-822-7196.

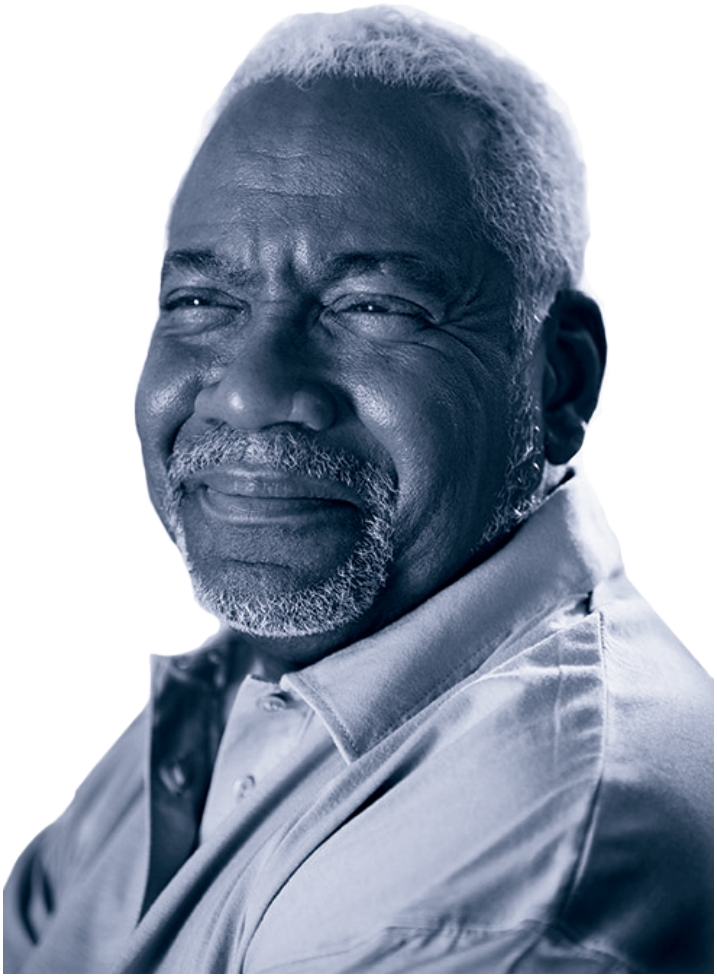
MDWISE COMMITMENT TO QUALITY CARE

MDwise is always looking for new ways to improve your health and to serve you better. The Quality Program wants MDwise members to get high quality health care services. Health services that are safe and meet your needs are important to us.

We monitor your care and services throughout the year. Our Quality program looks at:

- Services given by doctors/providers
- Members being able to get the services they need
- Members getting the right number of services
- Results of our member satisfaction surveys

What we find from these reviews helps us to work closely with providers. Results also help us know what information to send to our members.



HOW TO GET HELP WITH A PROBLEM

Getting Help with a Problem

The quality of service you get from MDwise is important to us. If you have a concern, call the MDwise Customer Service Department at: 1-877-822-7196 or in the Indianapolis area 317-822-7196.

A MDwise customer service representative will file a grievance. The customer service representative will try to solve your concerns right away. If we cannot solve the issue by the next business day, we will follow up with a letter.

Filing an Appeal

If you do not agree with a decision you get, you have the right to ask for further review of the problem. This is called an "appeal." You can file an appeal about any health care decisions. Someone, like your doctor, can do this on your behalf if you want them to.

You must file an appeal within 30 days of the date that the decision was made. When you file an appeal, you may be able to continue getting a service that has been denied. This can only happen if you are getting those services already. You must send your appeal in before the denial takes effect. If MDwise decides that the services will not be authorized, you will have to pay for those services. Ask us about continued services if this is important to you.

How to File an Appeal:

Step 1. Submit Your Appeal

You must write a letter. You can call the MDwise Customer Service Department for help writing your letter. When you write a letter, you should include the following:

- Your name, address, telephone number, and MDwise card number.
- Date and description of the service that was denied
- Additional information that can help in our review
- You must sign the letter

Keep a copy of these papers for yourself.
Then, send us the original at:
MDwise Customer
Service Department
Attn: Appeals
PO Box 44236
Indianapolis, IN 46244-0236

Step 2. Wait for a Written Answer from MDwise

MDwise will review your appeal.
You will get a letter telling how we handled your problem. We will reply within 25 business days. If we need more time to review the problem we will write to you and let you know.

Step 3. MDwise Second Level Appeal Process

If you still do not agree with our answer, you can ask for an appeal by calling MDwise. You must also write us a letter to appeal. You have 30 business days to file an appeal. The MDwise Appeals Panel will review your problem. You can speak to the panel if you want. You can also have someone else speak for you. You will get a reply within 35 business days.

Step 4. Review by Independent Review Organization

If you are still not happy, you can sometimes ask for a review by an Independent Review Organization (IRO). The IRO will make a decision within 15 business days and MDwise will then notify you of the results.

Step 5. Appeal to FSSA

To appeal the IRO decision, you must contact the State. The Indiana FSSA Office of Hearings and Appeals handles this. You can write to them at:
Office of Hearings and Appeals, 402 West Washington, Room W392, Indianapolis, IN 46204. The FSSA decision is the final administrative ruling. If you are still not happy, you can file a lawsuit. A court will then review your case.

Other Notes: In an emergency, appeals will be handled quickly. This is called an "expedited" appeal. If your case can be expedited, we will review your case and notify you of a decision within 72 hours. Call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196 to see if this can be done.

YOUR RIGHTS AND RESPONSIBILITIES

MDwise provides access to medical care for all its members. We do not discriminate based on your religion, race, national origin, color, ancestry, handicap, sex, sexual preference, or age.

Medical care is based on scientific principles. We provide care through a partnership that includes your doctor, MDwise, other health care staff, and you – our member.

MDwise is committed to partnering with you and your doctor. We will:

- Treat you and your family with dignity and respect.
- Maintain your personal privacy. Keep your medical records confidential as required by law.
- Give you a clear explanation of your medical condition. You have a right to be part of all your treatment decisions. If you understand the options, you can better decide if you want a certain treatment Options will be discussed with you no matter what they cost or whether they are covered as a benefit.
- Provide you with information about MDwise, its services, and doctors.

In addition, YOU have the right to:

- Change your doctor once each year by calling the MDwise Customer Service Department.
- Timely access to covered services.
- Appeal any decisions we make about your health care. You can also complain about personal treatment you get.
- Get copies of your medical records or limit access to these records, according to state and federal law.
- Amend your medical records that we keep.
- Get information about your doctor.
- Request information about the MDwise organization and operations.
- Refuse care from any doctor.
- Ask for a second opinion.
- Make complaints about MDwise, its services, doctors, and policies.
- Get timely answers to your complaints or appeals.
- Take part in member satisfaction surveys.
- Prepare an advance directive.
- Get help from the Indiana Family and Social Services Administration (FSSA) about covered services, benefits, or complaints.
- Get complete benefit information. This includes how to get services during regular hours, emergency care, after-hours care, out-of-area care, exclusions, and limits on covered services.
- Request information about our physician incentive plan.
- Be told about changes to your benefits and doctors.
- Be told how to choose a different health plan.
- Health care that makes you comfortable based on your culture.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, in accordance with Federal regulations. This means that your doctor cannot restrain or seclude you because it is the easiest thing to do. The doctor cannot make you do something that you do not want to do. The doctor cannot try to get back at you for something that you may have done.
- When you exercise these rights, you will not be treated differently.
- Provide input on MDwise member rights and responsibilities.
- Participate in all treatment decisions that affect your care.
- If MDwise closes or becomes insolvent, you are not responsible for our debts. Also, you would not be responsible for services that were given to you because the State does not pay MDwise, or that MDwise does not pay under a contract. Finally in the case of insolvency, you do not have to pay any more for covered services than what you would pay if MDwise provided you the services directly.

YOU are responsible for:

- Contacting your doctor for all your medical care.
- Treating the doctor and their staff with dignity and respect.
- Understanding your health problems to the best of your ability and working with your doctor to develop treatment goals that you can both agree on.
- Telling your doctor everything you know about your condition and any recent changes in your health.
- Telling your doctor if you do not understand your care plan or what is expected of you.
- Following the plans and instructions for care that you have agreed upon with your doctor.
- Keeping scheduled appointments.
- Notifying your doctor 24 hours in advance if you need to cancel an appointment.
- Telling us about other health insurance that you have.

IMPORTANT TIP:
If you do not follow your doctor's advice, this may keep you from getting well. It is your job to talk with your doctor if you have any questions about your medical care. Don't ever be afraid to ask your doctor questions! It is your right!

NOTICE OF PRIVACY PRACTICES

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.

Dear MDwise Member,
This notice tells about your privacy rights. You have rights about the medical information we keep about you. MDwise cares about your privacy. We protect your privacy rights. Please call us at 1-877-822-7196 or in the Indianapolis area 317-822-7196, if you have questions about this notice. You can ask to see a copy of the medical information we keep about you. When you call, ask for the Privacy Officer.
Wishing you good health,
MDwise

Summary of Privacy Practices

We may use and disclose your medical information, without your permission, for treatment, payment, and health care operations activities and, when required or authorized by law, for public health and interest activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your health care or payment for health care, and to appropriate public and private agencies in disaster relief situations.

We will not otherwise use or disclose your medical information without your written authorization.
You have the right to examine and receive a copy of your medical information, to receive an accounting of certain disclosures we may make of your medical information, and to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Organizations Covered by this Notice
This notice applies to the privacy practices of MDwise, Inc.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect January 1, 2008, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. If we make a significant change in our privacy practices, we will change this notice and send you a new notice within sixty (60) days of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information at the end of this notice.

Uses and Disclosures of Medical Information

We will use and disclose medical information about you for treatment, payment, and health care operations. For example:
Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to determine eligibility, process claims, or make payment for covered services you receive under your benefit plan. Also, we may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include, for example, health care quality assessment and improvement activities and general administrative activities.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your health care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement. We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your health care in appropriate situations, such as a medical emergency or during disaster relief efforts.

Before we make such a disclosure, we will provide you with an opportunity to object. If you are not present or are incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services and Appointment Reminders: We may contact you to remind you of appointments. We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services, that we provide or include in our benefits plan, and about treatment alternatives that may be of interest to you. These communications may include information about the health care providers in our network, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to, although they are not part of, our benefits plan.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and interest activities, judicial and administrative proceedings, law enforcement, research, and other public benefit functions:

- For public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- To avert a serious and imminent threat to health or safety;
- For health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention enforcement agencies;
- For research;
- In response to court and administrative orders and other lawful process;
- To law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying or locating suspects or other persons;
- To coroners, medical examiners, funeral directors, and organ procurement organizations;
- To the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- As authorized by state worker's compensation laws.

Individual Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You must make a written request to obtain access to your medical information. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact us using the information at the end of this notice for information about our fees.

Disclosure Accounting: You have the right to a list of instances after January 1, 2008, in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before January 1, 2008. 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 your additional requests. Contact us using the information at the end of this notice for information about our fees.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing, and it must explain why the information should be amended. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. You may

obtain a form from that contact to make your request. Any agreement we may make to a request for restriction must be in writing signed by a person authorized to bind us to such an agreement.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by alternative means or to alternative locations that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

We will accommodate your request if it is reasonable, specifies the alternative means or location for confidential communication, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber of that health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Right to Obtain a Paper Copy: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your medical information, you may complain to us using the contact information at the end of this notice. You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office of Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: MDwise
Attention: Privacy Officer
Telephone: 1-877-822-7196 or in the Indianapolis area 317-822-7196
E-mail: legal@mdwise.org
Address: P.O. Box 44236, Indianapolis, IN 46244-0236

Milliman

ENCLOSURE 2

Your Anthem Benefits

Anthem

State of Indiana Benefits Comparison
Summary of Benefits for 2010

	CONSUMER-DRIVEN HEALTH PLAN 1	CONSUMER-DRIVEN HEALTH PLAN 2	TRADITIONAL PPO
Deductible (Single/Family) **Deductibles are co-mingled Network and Non-network for Consumer-Driven Health Plans ONLY**	$ 2,500 single Network/Non-network $ 5,000 family Network/Non-network The Family deductible must be satisfied by either one Enrollee or all Enrollees collectively before any Covered Services are paid by the Plan. The Single deductible does not apply to a family plan.	$ 1,500 single Network/Non-network $ 3,000 family Network/Non-network The Family deductible must be satisfied by either one Enrollee or all Enrollees collectively before any Covered Services are paid by the Plan. The Single deductible does not apply to a family plan.	**Network/Non-Network** $500 single/$1000 single $1000 family/$2000 family The Family deductible must be satisfied by either one Enrollee or all Enrollees collectively before any Covered Services are paid by the Plan. The Single deductible does not apply to a family plan.
Out of Pocket Maximum (Single/Family) **Out of pockets are co-mingled Network and Non-network for Consumer-Driven Health Plans ONLY**	$4,000 single coverage $8,000 family coverage The Family out-of-pocket limit must be satisfied by either one Enrollee or all Enrollees collectively before it applies under the Plan. The Single out-of-pocket limit does not apply to a family plan. Includes the deductible	$3,000 single coverage $6,000 family coverage The Family out-of-pocket limit must be satisfied by either one Enrollee or all Enrollees collectively before it applies under the Plan. The Single out-of-pocket limit does not apply to a family plan. Includes the deductible	**Network/Non-Network** $2000 single/$4000 single $4000 family/$8000 family The Family out-of-pocket limit must be satisfied by either one Enrollee or all Enrollees collectively before it applies under the Plan. The Single out-of-pocket limit does not apply to a family plan. Includes the deductible
	Note: The out of pocket maximum limit includes all Deductibles and/or Coinsurance you incur in a Benefit Period. After you or the Family collectively have met the out-of-pocket limit, the plan will begin paying 100% of covered charges for the remainder of that calendar year except for non-network Human Organ Tissue Transplant services.	**Note:** The out of pocket maximum limit includes all Deductibles and/or Coinsurance you incur in a Benefit Period. After you or the Family collectively have met the out-of-pocket limit, the plan will begin paying 100% of covered charges for the remainder of that calendar year except for non-network Human Organ Tissue Transplant services.	**Note:** The out of pocket maximum limit includes all Deductibles and/or Coinsurance you incur in a Benefit Period. After you or the Family collectively have met the out-of-pocket limit, the plan will begin paying 100% of covered charges for the remainder of that calendar year except for non-network Human Organ Tissue Transplant services.

	CONSUMER-DRIVEN HEALTH PLAN 1	CONSUMER-DRIVEN HEALTH PLAN 2	TRADITIONAL PPO
Professional Office Services Including allergy – testing and treatment – serum and injections	20% Network/40% Non-network per visit	20% Network/40% Non-network per visit	20% Network/40% Non-network per visit
Preventive Care Services Services include but are not limited to: Annual Physical Exams, Pelvic Exams, Pap testing, PSA tests, immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility • Routine Mammograms • Screening Colorectal Cancer Exam/Laboratory Testing **All preventive services are limited to one of each service per year per covered member**	**Covered In Full Network**/40% Non-network Both In-Network and Out-of Network Not subject to deductible	**Covered In Full Network**/40% Non-network Both In-Network and Out-of Network Not subject to deductible	**Covered In Full Network**/40% Non-network Both In-Network and Out-of Network Not subject to deductible
Medical Supplies, Equipment & Appliances	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network
Maternity Services	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network
Inpatient Facility Services	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network
Outpatient Facility Services	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network
Professional Inpatient/Outpatient Services	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network
Emergency and Urgent Care: • Emergency Care in ER Room • Urgent Care Facility	20% Network/20% Non-network	20% Network/20% Non-network	20% Network/20% Non-network
Ambulance	20% Network/20% Non-network	20% Network/20% Non-network	20% Network/20% Non-network
Outpatient Therapy Services (Combined Network and Non-network limits apply) Limits apply to: • Physical therapy: 25 visits • Occupational therapy: 25 visits • Manipulation therapy: 12 visits • Speech therapy: 25 visits	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network

	CONSUMER-DRIVEN HEALTH PLAN 1	CONSUMER-DRIVEN HEALTH PLAN 2	TRADITIONAL PPO
Diabetes Self Management Training	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network
Diagnostic Services (i.e. lab, x-ray, MRI)	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network
Temporomandibular Joint (TMJ) Services • Outpatient Facility • Provider Individual • TMJ Surgery - Professional Services	 20% Network/40% Non-network 20% Network/40% Non-network 20% Network/40% Non-network $2,500 lifetime maximum for all services (Network/Non-network)	 20% Network/40% Non-network 20% Network/40% Non-network 20% Network/40% Non-network $2,500 lifetime maximum for all services (Network/Non-network)	 20% Network/40% Non-network 20% Network/40% Non-network 20% Network/40% Non-network $2,500 lifetime maximum for all services (Network/Non-network)
Hospice	20% Network/20% Non-network	20% Network/20% Non-network	20% Network/20% Non-network
Home Health Care No RN/LPN unless billed through a Home Health Care Agency	20% Network/40% Non-network Private Duty Nursing limited to $5,000 plan maximum per enrollee	20% Network/40% Non-network Private Duty Nursing limited to $5,000 plan maximum per enrollee	20% Network/40% Non-network Private Duty Nursing limited to $5,000 plan maximum per enrollee
Home IV Therapy	20% Network/40% Non-network	20% Network/40% Non-network	20% Network/40% Non-network

	CONSUMER-DRIVEN HEALTH PLAN 1	CONSUMER-DRIVEN HEALTH PLAN 2	TRADITIONAL PPO
Managed Mental Health including Substance Abuse	20% Network/40% Non-network Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed.	20% Network/40% Non-network Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed.	20% Network/40% Non-network Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed.
Human Organ and Tissue Transplants (HOTT) Specialty Network	20% Network/40% Non-network See contract for other maximums and exclusions	20% Network/40% Non-network See contract for other maximums and exclusions	20% Network/40% Non-network See contract for other maximums and exclusions
Lifetime Maximum includes Human Organ and Tissue Transplants (HOTT)	$2 million Network and Non-network combined	$2 million Network and Non-network combined	$2 million Network and Non-network combined

Prescription Drug Coverage – THIS COVERAGE IS ADMINISTERED BY MEDCO[1]

Below benefits apply after medical deductible has been met; prescription expenses accumulate to the OOP maximum

	Retail Rx (Up to a 30 Day Supply)	Mail Order Rx (Up to a 90 Day Supply)
Generic	$10 co-pay	$20 co-pay
Formulary	20% - minimum $30, maximum $50	20% - minimum $60, maximum $100
Brand Non-Formulary	40% - minimum $50, maximum $70	40% - minimum $100, maximum $140
Specialty	40% - minimum $75, maximum $150 (30-day supply only)	

See Benefit Booklet for exclusions

Notes:

- [1]***Prescription benefits are being administered by Medco. Any questions related to prescription coverage should be directed to (877)841-5241.***
- *Non-network human organ and tissue transplants are excluded from the out-of-pocket limits*
- *Dependent age: to the end of calendar year of the child's 19th birthday; or to the end of the calendar year of the child's 23rd birthday if the Dependent qualifies as a Full Time Student.*
- *No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.*
- *Benefit period = calendar year*
- *Prosthetic limbs are unlimited and do not apply to the plan lifetime maximum.*
- *We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.*
- *Kidney and Cornea transplant services are treated the same as any other illness and subject to the medical benefits.*

Precertification:

- *Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Blue View Vision Select℠

STATE OF INDIANA

STATE OF INDIANA has selected Anthem Blue View Vision Select as your vision wellness program. Blue View Vision Select offers you one of the most robust vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision's select network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters®, Target Optical®, JCPenney® Optical, Sears Optical℠, and Pearle Vision® stores. Best of all – when you receive care from a Blue View Vision Select participating provider, you can maximize your benefits and money-saving discounts. Members may call Blue View Vision Select toll-free at (877) 254-9443 with questions about vision benefits or provider locations.

Out-of-Network Services
Did we mention we're flexible? You can choose to receive care outside of the Blue View Vision Select network. You simply get an allowance toward services and you pay the rest. (In-network benefits and discounts will not apply.) Just pay in full at the time of service and then file a claim for reimbursement.

LENSCRAFTERS
PEARLE VISION
OPTICAL
JCPenney jcp.com
Sears Optical

Vision Care Services	Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary	$10 Copay	Up to $35
Contact Lens Fit and Follow-up: (A contact lens fitting and two follow-up visits are available to you once a comprehensive eye exam has been completed.)		
Standard*	$40 Copay Paid-in-full fit and two follow up visits	Up to $35
Premium**	10% off retail	Up to $35
Frames	Up to $110 allowance	Up to $35
Standard Plastic Lenses:		
Single Vision	$25 Copay	Up to $25
Bifocal	$25 Copay	Up to $40
Trifocal	$25 Copay	Up to $55
Standard Polycarbonate (add-on the lens copay)	$20 Copay	N/A
Lens Option (paid by member and added to the base price of the lens):		
Tint	$15	N/A
UV Coating	$15	N/A
Standard Scratch-Resistant	$15	N/A
Standard Progressive (add-on to bifocal)	$65	N/A
Standard Anti-Reflective	$45	N/A
Other Add-ons	20% off retail	N/A
Contact Lenses (allowance covers materials only):		
Conventional Elective	$0 Copay; $105 allowance 15% off balance over $105	Up to $95
Disposable Elective	$0 Copay; $105 allowance	Up to $95
Non-elective	$0 Copay; Paid in full	Up to $165
Low Vision (subject to prior approval)	$0 Copay $1,000 Lifetime Max.	$0 Copay $1,000 Lifetime Max.
Frequency:		
Exam	Once every 12 months	
Frames	Once every 24 months	
Standard Plastic Lenses or Contact Lenses	Once every 12 months	

*A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.
**A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the plan design; however, these materials and any items not covered below may be purchased at preferred pricing from a Blue View Vision Select provider. In addition, benefits are payable only for expenses incurred while the group and insured person's coverage is in force. Combined Offers. Not combined with any offer, coupon, or in-store advertisement; Experimental or Investigative. Any experimental or investigative services or materials; Crime or Nuclear Energy. Conditions that result from: (1) insured person's commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available; Uninsured. Services received before insured person's effective date or after coverage ends; Excess Amounts. Any amounts in excess of covered vision expense; Routine Exams or Tests. Routine examinations required by an employer in connection with insured person's employment; Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if insured person does not claim those benefits; Government Treatment. Any services actually given to the insured person by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if insured person is not required to pay for them or they are given to the insured person for free; Services of Relatives. Professional services or supplies received from a person who lives in insured person's home or who is related to insured person by blood or marriage; Voluntary Payment. Services for which insured person is not legally obligated to pay. Services for which insured person is not charged. Services for which no charge is made in the absence of insurance coverage; Not Specifically Listed. Services not specifically listed in this plan as covered services; Private Contracts. Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act; Eye Surgery. Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery; Sunglasses. Sunglasses and accompanying frames; Safety Glasses. Safety glasses and accompanying frames; Hospital Care. Inpatient or outpatient hospital vision care; Orthoptics. Orthoptics or vision training and any associated supplemental testing; Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power; Lost or Broken Lenses or Frames. Any lost or broken lenses or frames, unless insured person has reached a new benefit period; Frames: Discount is not available on certain frame brands in which the manufacturer imposes a no discount policy.

Anthem

BLUE VIEW VISION SELECT ADDITIONAL SAVINGS

	MEMBER SAVINGS
Additional Pair of Complete Eyeglasses	40% discount off retail*
Contact Lenses - Conventional *(Discount applied to materials only)* Visit www.eyemedcontacts.com to order replacement contact lenses for shipment to your home at less than retail price.	15% off retail price
Eyewear Accessories Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases, etc.	20% off retail price

*Items purchased separately are discounted 20% off the retail price. Blue View Vision Select's Additional Savings Program is subject to change without notice.

LASER VISION CORRECTION SURGERY

Glasses or contacts may not be the answer for everyone. That's why we offer further savings with discounts on refractive surgery. Pay a discounted amount per eye for LASIK Vision correction. For more information, go to SpecialOffers at www.anthem.com/specialoffers and select vision care.

USING YOUR BLUE VIEW VISION SELECT PLAN

The Blue View Vision Select network is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

OUT-OF-NETWORK

If you choose an out-of-network provider, please complete the out-of-network claim form and submit it along with your itemized receipt to the below fax number, email address, or mailing address. When visiting an out-of-network provider, you are responsible for payment of services and/or eyewear materials at the time of service.

To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
To Mail: Blue View Vision Select
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111