



Anthem 

Health. Join In.



HEALTHY INDIANA PLANSM
Health Coverage = Peace of Mind

Anthem Blue Cross and Blue Shield Healthy Indiana PlanSM

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.

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

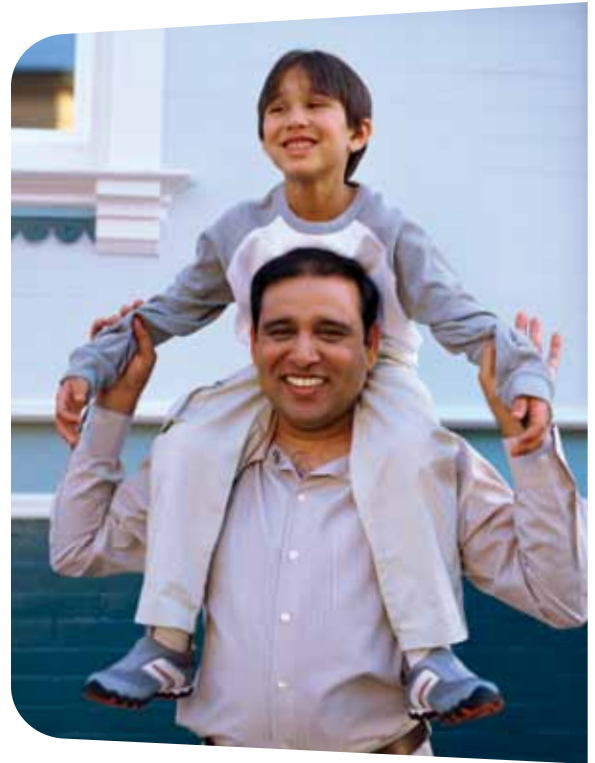
Anthem Blue Cross and Blue Shield's Healthy Indiana PlanSM (HIP) is a new, affordable health care program for uninsured adult Hoosiers. The program offers health benefits, including physician services, mental health services, and prescription drug coverage. The program is subsidized by the State of Indiana, 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	<p>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.</p> <p>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.</p>
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	<p>First \$500 per benefit period not charged to POWER Account</p> <p>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.</p>
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

<p>Human Organ and Tissue Transplant Services</p>	<p>Paid from POWER Account first, then 100% coverage from Anthem.</p>
<p> 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.) </p>	<p>Paid from POWER Account first, then 100% coverage from Anthem.</p>
<p> Maternity Care Dental Vision </p>	<p>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.</p>

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.



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.

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